

**VOLUME II**

**1968 PROCEEDINGS**

**OF THE**

**National Association of  
Insurance Commissioners**

**ANNUAL MEETING**

**HELD AT THE**

**PORTLAND HILTON HOTEL**

**PORTLAND, OREGON**

**JUNE 16-21, 1968**

# CONSTITUTION AND BY-LAWS

## Constitution

### ARTICLE 1 NAME:

This organization shall be known as the National Association of Insurance Commissioners.

### ARTICLE 2 OBJECT:

The object of this Association shall be to promote uniformity in legislation affecting insurance, to encourage uniformity in departmental rulings under the insurance laws of the several states; to disseminate information of value to insurance supervisory officials in the performance of their duties; to establish ways and means of fully protecting the interests of insurance policyholders of the various states, territories and insular possessions of the United States and to preserve to the several states the regulation of the business of insurance.

### ARTICLE 3 MEMBERSHIP:

The membership of this Association shall consist of the commissioner, director, superintendent or other official who by law is charged with the responsibility of supervising the business of insurance within each state, territory or insular possession of the United States. Only members and their duly authorized representatives as defined in Article 4 hereof shall be eligible to hold office in the Association and to serve on committees of the Association. Members of the Association of Superintendents of Insurance of the Provinces of Canada and the Commissioner of Insurance of the Republic of the Philippines shall be eligible to participate in all meetings of this Association without the power to vote.

### ARTICLE 4 POWER TO VOTE:

Each member of the Association shall have the power to vote either in person or if absent by delegating such power in writing to a duly authorized representative who shall be some person officially connected with his department, who is wholly or principally employed by said department and who is a legal resident of the state, territory or insular possession wherein the department is located. No state, territory or insular possession shall have more than one vote.

### ARTICLE 5 OFFICERS:

Officers of the Association shall be a President, a Vice-President, and a Secretary-Treasurer, who shall be elected by secret ballot at the annual meeting, and shall hold office until the next annual meeting and the election and qualification of their successors.

### #\*ARTICLE 6 COMMITTEES:

#### CONSTITUTIONAL

*Executive Committee:* There shall be an Executive Committee consisting of the Chairman and three members at large, all of whom shall be elected at the annual meeting, the officers of the Association, ex officio, the retiring President who shall be Vice-Chairman, and six members, one from each zone, to be elected annually by the members of the respective zones prior to or during the Association's annual meeting.

*Examinations Committee:* There shall be an Examinations Committee consisting of the duly elected zone Chairmen who shall elect a chairman and a vice-chairman from its own membership.

### #\*STANDING

As soon as convenient after the annual meeting, the president shall appoint from the members of the Association the Chairman, Vice-Chairman, the members of the following Standing Committees, and such other special committees as may be necessary. Industry committees may be authorized by action of the Association.

#### Blanks

##### Subcommittees:

Fire, Casualty & Reciprocal Blank  
Life, Accident & Health Blank  
Fraternal Blank  
Hospital & Medical Service Plans Blank  
Title Insurance Blank

#### Federal Liaison

##### Subcommittee:

Preservation of State Regulation

\*Amended June 1959 — See 1959 Proc., VOL. II, page 393.  
#Amended 1965 Proc., Vol. II pp. 275-277.

Laws and Legislation

Subcommittees: None

Life, Accident and Health

Subcommittees:

Accident and Health  
 Credit Life and Credit Accident and Health  
 Fraternal  
 Life  
 Non-Profit Hospital and Medical Service Associations

Property, Casualty and Surety

Subcommittees:

Rates and Rating Organizations  
 Unauthorized Insurers

Valuation of Securities

Subcommittee:

Valuation of Securities

SPECIAL

Advertising of Insurance

Subcommittees: None

ARTICLE 7 MEETINGS:

The Association shall hold an annual meeting in the month of June at such time and place as the Executive Committee may designate. The Association shall also hold a regular meeting in the month of December at such time and place as the Executive Committee may designate. Special meetings may be called by any five members of the Executive Committee by giving all members notice of such meeting at least ten days prior thereto, or by any fifteen members of the Association upon thirty days notice to all members. Actions at any special meetings shall be limited to the objects stated in the notice therefor. At any meeting of the Association, one or more of the sessions may be Executive sessions if directed by the Executive Committee and shall be so announced with attendance limited to members and representatives of the insurance department specially designated by members.

ARTICLE 8 QUORUM:

A quorum for the transaction of business shall consist of twenty-five members or their duly authorized representatives qualified to vote.

ARTICLE 9 \*ELECTIONS:

For the purposes of this Association, the United States and its territories and insular possessions shall be divided into six zones, each zone consisting of a group of at least eight states located in the same geographical area with each state being contiguous to at least one other state in the group so far as practicable, plus any territory or insular possession as may be deemed expedient, all as determined by a majority of the Executive Committee. Members of each zone shall annually elect a Chairman and a Vice-Chairman from its membership and shall perform such functions as are designated by the Constitution and By-Laws of the Association, or by the members of the Association, or by the members of the Association or zone at any meeting. No member shall hold office of President, Vice-President, Secretary-Treasurer, Chairman of the Executive Committee for more than two consecutive years.

\*VACANCIES:

Vacancies in any of the offices or in the members-at-large of the executive committee may be filled by the executive committee for the remaining period until the next ensuing annual or semi-annual meeting of the Association. In the event of such vacancy, the chairman of the executive committee or, in case of his inability to act from any cause, the vice-chairman, or if he be unable, the president may call a meeting of or conduct a mail ballot among the members of the executive committee to fill such vacancy until the ensuing meeting of the Association. When the ensuing meeting is a semi-annual meeting, the vacancy shall be filled until the ensuing annual meeting by secret ballot of the Association. If the vacancy is that of a member elected to represent a zone on any committee, the Chairman of the zone, or in his absence the Vice-Chairman, shall immediately call a meeting of or conduct a mail ballot among the members of the zone to fill such a vacancy. In case the immediate past President

\*Amended December, 1957 — See 1958 Proc. Vol. I, page 43.

is unable, for any reason, to act as Vice-Chairman of the Executive Committee as provided for in the first paragraph of ARTICLE 6, the membership of the Executive Committee shall elect one of its members to act as Vice-Chairman.

**ARTICLE 10 REVENUE:**

To provide for expenses authorized by the Executive Committee, the secretary-treasurer shall solicit voluntary contributions from the members. To provide for the expense of the Committee on Valuation of Securities the chairman thereof shall solicit voluntary contributions from the members. In the event that any member shall have the authority by statute or otherwise to enter into an agreement with the Committee on Valuation of Securities or with this Association to provide funds for the expenses of the said Committee, the Chairman shall enter into any agreement or agreements with such member as may be or become necessary for such purpose.

**ARTICLE 11 BY-LAWS:**

The by-laws of the Association may prescribe the powers and duties of the several officers and committees of the Association and such rules as may be needful for the work of the Association provided they are in conformity with this constitution.

**ARTICLE 12 AMENDMENTS:**

This Constitution may be altered or amended at any meeting of the Association by an affirmative vote of the majority of the members qualified to vote, or their duly authorized representatives provided that previous notice of the proposed amendment has been mailed to all members by the secretary-treasurer or the chairman of the Executive Committee at least thirty days prior to the meeting.

## By-Laws

**SECTION 1 DUTIES OF OFFICERS:**

The duties of the several officers shall be such as usually devolve upon those holding like positions.

**\*SECTION 2 DUTIES OF EXECUTIVE COMMITTEE:**

The regular meetings of the Executive Committee shall be held at such times and places as it may designate. Special meetings may be held when called by the president, by the chairman or by three members of the Executive Committee in writing; at least five (5) days' notice shall be given of all special meetings.

The Executive Committee shall have the management of all of the affairs of the Association unless otherwise provided for and may, with the concurrence of three-fourths of its membership, establish rules for its own conduct that shall not conflict herewith, which rules may be changed only by a like concurrence after twenty-four (24) hours' notice to members of the Committee.

\*The Association may also employ an Executive-Secretary who shall not be a member of the Association. The Executive Committee shall have the authority to select such Executive-Secretary annually subject to the approval of the Association.

It shall cause to be kept full and complete minutes of its meetings and have information of any action of a general character, taken by it, published to members qualified to vote.

It shall make an annual report to the membership covering the business of the preceding year, and such special reports from time to time as may be agreed upon.

It may, upon the recommendation of any standing or special committee and after due notice to the membership, recommend rules, regulations and practices to be followed by the various administrative bodies in the administration of insurance laws.

**‡\*SECTION 3 DUTIES OF COMMITTEE ON EXAMINATIONS:**

The Committee on Examinations shall make arrangements for Association examinations, by representatives of insurance supervisory officials of two or more states, of companies, associations or organizations engaged in the insurance business when requested by the supervisory official of the state in which the company, association or organization to be examined is domiciled or at the request of two or more other officials representing states in which such insurance company, association or organization is duly authorized to transact business; provided, however, if the insurer is authorized to transact business in its state of domicile and only two other states, the Committee



may act upon the request of only one other official, and provided, further, that no such examination shall be arranged unless the Committee on Examinations first obtains the consent of the supervisory official of the state of domicile, or in the event such consent is withheld, the Committee is satisfied that the best interests of the public and of state supervision would be served by conducting such examination without such consent.

With respect to any insurer which is authorized to transact business only in its state of domicile or in the state of domicile and only one other state, in the event that the supervisory official of the state of domicile of the company does not request such an examination, then the supervisory official of such other state or the supervisory official of the state of domicile of any other insurer which has a contract of reinsurance with such insurer or any other kind of a contract affecting the insurer's condition may request the Committee on Examinations to arrange for an Association examination. If after investigation the Committee on Examinations feels that an Association examination is warranted, it shall arrange for the examination. Any supervisory official affected by the request for an Association examination shall be given full opportunity to be heard before the Committee on Examinations.

In the selection of states to participate in Association examinations, the Committee shall, insofar as practicable, select states that will insure a fair geographical representation of all of the states interested.

The Committee on Examinations shall prepare and maintain a Manual of Association Examination Practice and Procedure.

#### SECTION 4 DUTIES OF COMMITTEE ON VALUATION OF SECURITIES:

The Committee on Valuation of Securities shall prepare or arrange to have prepared immediately following the end of each calendar year a book containing the recommendations of the Association for the valuation of securities owned by insurance companies and associations in the preparation of their annual financial statements.

No valuation shall be published unless the basis upon which it is predicated shall have been first approved and adopted by the Association.

The Valuation of Securities Subcommittee, subject to the authority of the valuation committee, shall secure proper office facilities and personnel and shall be responsible for the operation of such office. It shall make complete reports to the valuations committee of such operation and shall make recommendations for valuations and rules to the committee.

#### SECTION 5 DUTIES OF COMMITTEE ON BLANKS:

The Committee on Blanks shall hold one or more meetings annually at the call of the chairman for the purpose of considering amendments to the various Association annual statement blanks. Following such meetings the Committee shall submit its report with recommendations to the Executive Committee and the Executive Committee shall consider such report and refer the same with such recommendations as it deems necessary to the Association. It shall be the duty of the Committee on Blanks to prepare blanks in accord with the action taken by the Association and have them distributed to all members of the Association.

#### SECTION 6 DUTIES OF FEDERAL LIAISON COMMITTEE:

Meetings of the Federal Liaison Committee shall be held at such times and places as may be designated by the chairman or a majority of members. The committee shall consider such matters as may be referred to it by the Association, and shall report its findings and recommendations to the Association. It may also within its discretion confer with agencies of the federal government and consider matters not specifically referred by the Association. It may make such reports to the Association as it shall deem advisable on such matters.

#### SECTION 7 GENERAL DUTIES OF STANDING AND SPECIAL COMMITTEES:

The meetings of Standing and Special Committees shall be held at such times and places as may be designated by their respective chairmen or memberships. The committees shall consider such matters as may be referred to them by the Association and report to the Association their findings, conclusions and recommendations thereon for action by the Association. A Committee may in the discretion of its respective membership consider matters within the general scope of its authority which have not been specifically assigned by the Association and may make such reports to the Association as they deem advisable on such matters.

**ASSIGNMENTS OF SUBJECTS:**

Any member desiring to introduce a subject for consideration shall forward such matter to the office of the Executive Secretary at least thirty days prior to the next meeting of the Association. The Executive Secretary shall, subject to the direction of the Vice-President, assign such matters to the proper committee through its chairman. The committee chairman shall, in his discretion, determine the time and method of consideration of such assignment by the committee; which shall make such report to the Association as it deems advisable.

**SUBCOMMITTEES:**

Subcommittees other than the Valuation of Securities Subcommittee may be appointed by the chairman of standing committees or elected by members of committees from the membership of the Association. A majority of the members of a subcommittee shall be members of the Standing Committee. Any vacancy occurring in the membership of such subcommittee shall be filled by the chairman of the Standing Committee.

In the event that a subcommittee upon recommendation of the Standing Committee is continued by act of the Association beyond the time of the annual meeting, the incoming chairman of the Standing Committee may appoint additional members to the subcommittee, and shall fill any vacancies occurring thereon. At least a majority shall be members of the Standing Committee. Subcommittee reports shall be addressed and submitted to the Chairman of the Standing Committee.

**REPORTS OF COMMITTEES:**

Committee reports and recommendations to the Association shall be addressed to the President and made in two sections:

Section A shall consist of factual matter relating to the committee work; any pertinent material or information which the committee desires to have included in the report, and any recommendations concerning adoption of resolutions in Section B by the Association. The motion shall be upon acceptance of the report without amendment.

Section B shall consist of specific resolutions individually listed, and for each resolution the motion shall be on its adoption by the Association with or without amendment

**SECTION 8 PROCEDURE:**

The Association shall be governed by Roberts Rules of Order.

**SECTION 9 AMENDMENTS:**

These By-Laws may be altered or amended at any meeting of the Association by an affirmative vote of a majority of the members or duly authorized representatives of members, present and qualified to vote, provided that previous notice of the proposed amendment has been mailed to all members by the secretary or the chairman of the Executive Committee at least thirty days prior to the meeting.

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\*Amended December 1956—Ref: 1957 Proc. VOL. I p. 42.  
†Amended June 1961—Ref: 1961 Proc. VOL. II p. 435.

NAIC 1968 ANNUAL MEETING - PORTLAND, OREGON - JUNE 16-21, 1968

AGENDA-IN-BRIEF

<i>SUN. P.M.</i>		<i>JUNE 16, 1968</i>	<i>RM. MTG.</i>	
2:30- 3:30	To Study Mortality & Morbidity Exper. of Credit Ins. (E2a) Sub.		G2	1
2:30- 3:30	To Review Statistical Plans (F1a) Subcom.		PE	2
3:30- 5:30	#Liaison with State Agencies (A4) Subcom.		#PC	#3
<i>MON. A.M.</i>		<i>JUNE 17, 1968</i>		
9:00-10:00	+To Prepare Model Legis. to Modify Schedule "P" (D1) Sub.		+BB	+4
9:00-10:00	Accident and Health Insurance (E1) Subcom.		BA	5
9:00-10:00	Non-Profit Hosp. and Medical Service Associations (E5) Sub.		PC	6
9:00-10:00	Joint Industry Study of Mortgage Ins. Problems (F4) Sub.		G2	7
9:00-10:00	+Actuarial (F5) Subcom.		+BB	+8
10:00-11:00	Examinations Procedures for Rating & Stat. Org'ns. (B4) Sub.		PC	9
10:00-11:00	Life Insurance (E4) Subcom.		BB	10
10:00-11:00	Hurricane-Flood and Related Insurance (F3) Subcom.		BA	11
10:00-11:00	To Consider Premium Financing by Insurers (F6) Subcom.		G2	12
11:00-12:00	To Study Reorganization and Public Inform. Matters (A3) Sub.		BA	13
11:00-12:00	Examinations Manual Revision (E1) Subcom.		PC	14
11:00-12:00	To Make Recommendations . . . re Unauth. Insurers (D4) Sub.		BB	15
11:00-12:00	Reorg., Receivership & Liquidation Procedures (D5) Sub.		G2	16
<i>MON. P.M.</i>		<i>JUNE 17, 1968</i>		
1:30- 2:30	To Study Future Sites for NAIC Meetings (A1) Subcom.		G2	17
1:30- 2:30	To Make Recommend. . . re Long Term Credit Ins. (D3) Sub.		BB	18
1:30- 2:30	To Study Regulations of Financial Guarantees (F8) Sub.		PC	19
1:30- 2:30	Valuation of Securities (G1) Subcom.		BA	20
2:30- 3:30	Uninsured and Partially Uninsured Non-Reg. Plans (A2) Sub.		G2	21
2:30- 3:30	To Study Exper. . . re Proxy Insider Trading Regs. (D6) Sub.		PC	22
2:30- 3:30	Variable Annuities (E6) Subcom.		BA	23
2:30- 3:30	Unauthorized Insurers (F2) Subcom.		BB	24
3:30- 4:30	Examinations of Accts. & Records by Electronic Comp. (B2) Sub.		PC	25
3:30- 4:30	To Draft Legis. Relating to Holding Companies (D2) Sub.		G2	26
3:30- 4:30	Rates and Rating Organizations (F1) Subcom.		BB	27
3:30- 5:30	Credit Life and Credit Accident and Health Ins. (E2) Sub.		BA	28
<i>TUES. A.M.</i>		<i>JUNE 18, 1968</i>		
9:00-10:15	MEXICO INSURANCE PROBLEMS (A6) COMMITTEE		PC	29
9:00-10:15	CIVIL DISORDERS - INSURANCE PROBLEMS (A7) COM.		BB	30
9:00-10:15	FEDERAL LIAISON (C) COMMITTEE		BA	31
9:00-10:15	ADVERTISING OF INSURANCE (H) COMMITTEE		G2	32
10:30-12:00	PLENARY SESSION - 1		BA	33
<i>TUES. P.M. No Meetings Scheduled -- JUNE 18, 1968 -- Publication of Reports</i>				
<i>WED. A.M.</i>		<i>JUNE 19, 1968</i>		
9:00-10:15	LAWS AND LEGISLATION (D) COMMITTEE		BA	34
9:00-10:15	VALUATION OF SECURITIES (G) COMMITTEE		BB	35
10:30-12:00	EXAMINATIONS (B) COMMITTEE		BB	36
10:30-12:00	+PROPERTY, CASUALTY AND SURETY (F) COMMITTEE		+BA	+37
	+Additional Regulation of Special Prop. Coverages in connection with Installment Sales or Credit Transactions (F7) Subcom.		+BA	+38
<i>WED. P.M.</i>		<i>JUNE 19, 1968</i>		
1:30- 2:45	+BLANKS (A5) COMMITTEE		+BB	+39
	+Fire, Casualty and Reciprocal Blank (A5a) Subcom.		+BB	+40
1:30- 2:45	LIFE, ACCIDENT AND HEALTH INS. (E) COMMITTEE		BA	41
3:00- 4:00	ZONE 1 - BA - 42; ZONE 2 - BB - 43; ZONE 3 - G2 - 44;			
4:00- 5:00	ZONE 4 - BA - 45; ZONE 5 - BB - 46; ZONE 6 - G2 - 47			
<i>THUR. A.M.</i>		<i>JUNE 20, 1968</i>		
9:00-11:00	EXECUTIVE (A) COMMITTEE		BA	48
<i>THUR. P.M.</i>		<i>JUNE 20, 1968</i>		
2:00- 4:00	PLENARY SESSION - 2		BA	49
<i>FRI. A.M.</i>		<i>JUNE 21, 1968</i>		
9:30-11:00	#PLENARY EXECUTIVE SESSION - 3		#BA	50

(#EXECUTIVE SESSION) (+JOINT MEETING) (NMS-NO MEETING SCHEDULED)  
 MEETING ROOMS ON BALLROOM LEVEL - BA-BALLROOM A; BB-BALLROOM B;  
 G2-GALLERIA 2; PC-PARLOR C; PE-PARLOR E.

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<i>SUN. P.M.</i>	<i>JUNE 16, 1968</i>	<i>MTG.</i>
2:30-3:30 GALLERIA 2	Mortality & Morbidity Experience - Credit Life & A&H (E2a) Subcom.  Hon. Louis T. Mastos, Chm., Nev. Hon. Robert A. Short, V.Chm., Del.  1. Industry Advisory Committee Report. Ref: 1968 Proc. VOL. I pp. 147-211 2. Any other matter submitted for consideration.	1
2:30-3:30 PARLOR E	To Review Statistical Plans (F1a) Subcom.  Hon. Robert D. Haase by Stanley C. Du Rose, Chm., Wis.  1. Individual Risk Rating Programs on Statistical Plans. Refs: 1967 Proc. VOL. I p. 178 1967 Proc. VOL. II p. 451 1968 Proc. VOL. I p. 261 2. Any other matter submitted for consideration.	2
3:30-5:30 PARLOR C	#Liaison with State Agencies (A4) Subcom.  Hon. David O. Maxwell, Chm., Pa. Hon. Benjamin C. Neff, Jr., V.Chm., Nebr.  1. Report of interim activities. 2. Any other matter submitted for consideration.	#3
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<i>MON. A.M.</i>	<i>JUNE 17, 1968</i>	
9:00-10:00 BALLROOM B	+To Prepare Model Legislation to Modify Schedule "P" (D1) Subcom.  Hon. David J. Dykhouse, Chm., Mich.  1. Consideration of Previous Reports. Refs: 1965 Proc. VOL. I pp. 182-187 1966 Proc. VOL. II pp. 451-507 1967 Proc. VOL. I pp. 201-207 1967 Proc. VOL. II pp. 369-372; 497-513 1968 Proc. VOL. I pp. 113-115; 275-282  2. Any other matter submitted for consideration.	+4
9:00-10:00 BALLROOM A	Accident and Health Insurance (E1) Subcom.  Hon. Dudley A. Guglielmo, Chm., La. Hon. Durwood Manford, V.Chm., Texas  1. School Child Accident Insurance. Ref: 1968 Proc. VOL. I p. 138 2. Accident and Health Insurance with Cash Surrender or other Non-forfeiture Value — Industry Advisory Committee Report Ref: 1968 Proc. VOL. I p. 137 3. Standardization of Proof of Loss — Cancer policies (Mississippi) 4. Any other matter submitted for consideration.	5
9:00-10:00 PARLOR C	Non-Profit Hospital and Medical Service Associations (E5) Subcom.  Hon. Lorne R. Worthington, Chm., Iowa Hon. Broward Williams, V.Chm., Fla.  1. Blue Cross-Blue Shield Association's Annual Report of Research Projects. Ref: 1967 Proc. VOL. II pp. 404-443 2. Any other matter submitted for consideration.	6

<i>MON. A.M.</i>	<i>JUNE 17, 1968</i>	<i>MTG.</i>
9:00-10:00 GALLERIA 2	Joint Industry Study of Mortgage Insurance Problems (F4) Subcom.  Hon. Richard E. Stewart, Chm., N. Y.  1. Receipt and consideration of Industry Advisory Committee. Report on Interim Developments. Refs: 1967 Proc. VOL. I pp. 195-199 1967 Proc. VOL. II p. 496 1968 Proc. VOL. I pp. 269-274  2. Any other matter submitted for consideration.	7
9:00-10:00 BALLROOM B	+ Actuarial (F5) Subcom.  Hon. David J. Dykhouse by Robert A. Bailey, Chm., Mich. Hon. Richard S. L. Roddis by Christy P. Armstrong, V.Chm., Calif.  1. Consideration of Previous Reports. Refs: 1965 Proc. VOL. I pp. 182-187 1966 Proc. VOL. II pp. 451-507 1967 Proc. VOL. I pp. 201-207 1967 Proc. VOL. II pp. 369-372; 497-513 1968 Proc. VOL. I pp. 113-115; 275-282  2. Any other matter submitted for consideration.	+8
10:00-11:00 PARLOR C	Examinations Procedure for Rating & Stat. Organizations (B4) Subcom.  Hon. Richard E. Stewart by Alexander E. Fox, Chm., N. Y.  1. Consideration of views of Rating & Stat. Organizations. Refs: 1967 Proc. VOL. II p. 343 1968 Proc. VOL. I pp. 97-104  2. Consideration of views of State Supervisory Officials. 3. Any other matter submitted for consideration.	9
10:00-11:00 BALLROOM B	Life Insurance (E4) Subcom.  Hon. Frank R. Montgomery, Chm., W. Va. Hon. Robert D. Scharz, V.Chm., Mo.  1. Any matter submitted for consideration.	10
10:00-11:00 BALLROOM A	Hurricane-Flood and Related Insurance (F3) Subcom.  Hon. Broward Williams, Chm., Fla. Hon. Charles R. Howell, V.Chm., N. J.  1. Federal Government Flood Program (F3a) Subcom. NMS Hon. Charles R. Howell, Chm., N. J. 2. Status Report. 3. Any other matter submitted for consideration.	11
10:00-11:00 GALLERIA 2	To Consider Premium Financing by Insurers (F6) Subcom.  Hon. J. Richard Barnes, Chm., Colo.  1. Experience in Regulation of Premium Financing. Hon. Edwin S. Lanier, North Carolina 2. Health and Well-Being of a Service Company. R. Donald Beard, Executive Vice President IFCO, Inc. Fayetteville, North Carolina 3. Premium Financing. 4. Premium Budgeting. Edward W. Horne, Vice President & General Counsel AFCO, New York 5. Any other matter submitted for consideration.	12

<i>MON. A.M.</i>	<i>JUNE 17, 1968</i>	<i>MTG.</i>
11:00-12:00 BALLROOM A	To Study Reorganization and Public Information Matters (A3) Subcom.  Hon. T. Nelson Parker, Chm., Va. Hon. Richard E. Stewart, V.Chm., N. Y. 1. Report of interim Meetings. 2. Any other matter submitted for consideration.	13
11:00-12:00 PARLOR C	Examinations Manual Revision (B1) Subcom.  Hon. Richard S. L. Roddis, Chm., Calif. Hon. John F. Bolton, Jr., V.Chm., Ill. 1. Subject matter of Life Reinsurance by William Conley, Michigan Ref: 1968 Proc. VOL. I p. 95 2. PART A, Section VI, page A12, paragraph (1) (Maryland) Is there a need for clarifying the Handbook instruction because of Annual Statement Blank Instructions: page 1, item 18 — Life, Accident and Health Blank page 1, item 13 — Fire, Casualty Blank 3. Any other matter submitted for consideration.	14
11:00-12:00 BALLROOM B	To Make Recommendations . . . re Unauthorized Insurers (D4) Subcom.  Hon. James R. Faulstich, Chm., Ore. 1. Industry Advisory Committee Report. Ref: 1968 Proc. VOL. I p. 121 2. Draft of Model Legislation. Ref: 1968 Proc. VOL. I p. 121 3. Any other matter submitted for consideration.	15
11:00-12:00 GALLERIA 2	Procedures for Reorganization, Receivership & Liquidation (D5) Subcom.  Hon. John F. Bolton, Jr., Chm., Ill. 1. Study of Liquidation Act drafted by Wisconsin. 2. Any other matter submitted for consideration.	16
<hr/> <i>MON. P.M.</i>		
1:30-2:30 GALLERIA 2	<i>JUNE 17, 1968</i>  To Study Future Sites for NAIC Meetings (A1) Subcom.  Hon. J. Richard Barnes, Chm., Colo. 1. Selection of Hotels for 1971 Regular Meeting, Miami Beach, Fla. Ref: 1967 Proc. VOL. II p. 287 2. Consideration of Hotels for: 1972 Annual Meeting, Denver, Colo. 1972 Regular Meeting, Atlanta, Ga. 1973 Annual Meeting, Baltimore, Md. Ref: 1967 Proc. VOL. II p. 287 1973 Regular Meeting, Las Vegas, Nev. Ref: 1968 Proc. VOL. I p. 53 3. Consider pending invitations, including Arkansas, San Francisco and Salt Lake City. 4. New invitations, if any. 5. Any other matter submitted for consideration.	17
1:30-2:30 BALLROOM B	Long Term Credit Insurance . . . Recommendations to Regulate (D3) Subcom.  Hon. William G. Walton, Chm., Wyo. 1. Industry Advisory Committee Report. Ref: 1968 Proc. VOL. I pp. 119-120 2. Any other matter submitted for consideration.	18

<i>MON. P.M.</i>	<i>JUNE 17, 1968</i>	<i>MTG.</i>
1:30-2:30 PARLOR C	To Study Regulations of Financial Guarantees (F8) Subcom. Hon. Richard S. L. Roddis, Chm., Calif. 1. Any matter submitted for consideration.	19
1:30-2:30 BALLROOM A	Valuation of Securities (G1) Subcom. Hon. Richard E. Stewart, Chm., N. Y. Hon. Joseph G. Wood, V.Chm., Ind. 1. Approval of minutes of 3/29/68 Meeting of the Subcom. 2. Consideration of the request of the Arkansas Insurance Department for review of Procedures under which the shares of National Investors Life Insurance Company are valued. 3. Any other matter submitted for consideration.	20
2:30-3:30 GALLERIA 2	Uninsured and Partially Uninsured Non-Regulated Plans (A2) Subcom. Hon. J. Richard Barnes, Chm., Colo. Hon. Robert D. Haase, V.Chm., Wis. 1. Industry Study Committee Report. 2. Statement by Edward Mack, Jr., President of Mass. Insurance Consultants and Administrators, Inc., representing the National Foundation of Health, Welfare and Pension Plans, Inc. 3. Statements by other interested organizations. 4. H.R. 5741 — presented by The Hon. Robert D. Haase, Wisconsin 5. Any other matter submitted for consideration.	21
2:30-3:30 PARLOR C	To Study Administration Experience of Proxy Regs. and Insider Trading Regs. and Make Recommendations (D6) Sub. Hon. David Maxwell, Chm., Pa. 1. Any matter submitted for consideration.	22
2:30-3:30 BALLROOM A	Variable Annuities (E6) Subcom. Hon. Robert D. Haase, Chm., Wis. Hon. James H. Hunt, V.Chm., Vt. 1. Variable Annuities (E6) Subcom. Report of interim Meetings. 2. Industry Advisory Committee Report. Ref: 1968 Proc. VOL. I pp. 221-222 3. Variable Annuity Agents Examination Questions. 4. Status Report of States filing Variable Annuity Examinations with S.E.C. 5. Any other matter submitted for consideration.	23
2:30-3:30 BALLROOM B	Unauthorized Insurers (F2) Subcom. Hon. Donald Knowlton, Chm., N. H. Hon. Broward Williams, V.Chm., Fla. 1. Non-Admitted Insurers Information Office. Ref: 1968 Proc. VOL. I pp. 264-266 2. Any other matter submitted for consideration.	24



MON. P.M.

JUNE 17, 1968

MTG.

3:30-4:30  
PARLOR C

Examinations of Accts. & Records by Electronic Computers 25  
(B2) Subcom.

Hon. Richard S. L. Roddis, Chm., Calif.

1. Any matter submitted for consideration.

3:30-4:30  
GALLERIA 2

To Draft Legislation Relating to Insurance Holding Companies 26  
(D2) Subcom.

Hon. Benjamin C. Neff, Jr., Chm., Nebr.

1. Scope of Activities
  - (a) Draft of Model Legislation
  - (b) Review of New York Report
  - (c) Industry Advisory Committee  
Ref: 1968 Proc. VOL. I p. 117
2. Report of Meeting 5/9-10/68.
3. Any other matter submitted for consideration.

3:30-4:30  
BALLROOM B

Rates and Rating Organizations (F1) Subcom. 27

Hon. Robert D. Haase, Chm., Wis.

Hon. Richard S. L. Roddis, V.Chm., Calif.

1. To Review Statistical Plans (F1a) Subcom. Report  
(Mtg. 2)  
Ref: 1968 Proc. VOL. I p. 261
2. Study of Rates, Rating Organizations and Rating Laws.  
Analysis of Insurer Questionnaire Responses  
First Report — Ref: 1967 Proc. VOL. II pp. 453-480  
Second Report — Ref: 1968 Proc. VOL. I pp. 229-260
3. Proposed Meeting 7/17-19/68 — Palmer House,  
Chicago, Illinois
4. Any other matter submitted for consideration.

3:30-5:30  
BALLROOM A

Credit Life and Credit Accident and Health Insurance 28  
(E2) Subcom.

Hon. Louis T. Mastos, Chm., Nev.

Hon. Robert A. Short, V.Chm., Del.

1. Credit Life and Credit Accident & Health Insurance  
(E2) Subcom. (Report of Meeting 2/26-27/68 —  
Las Vegas, Nevada)
2. Mortality & Morbidity Experience of Credit Life and  
Credit Accident and Health Insurance (E2a) Subcom.  
Report (Mtg. 1)
3. Industry Advisory Committee Report.  
Ref: 1968 Proc. VOL. I pp. 147-211
4. Any other matter submitted for consideration.

TUES. A.M.

JUNE 18, 1968

9:00-10:15  
PARLOR C

MEXICO INSURANCE PROBLEMS (A6) COMMITTEE 29

HON. WALTER S. HOUSEAL, CHM., ALA.

HON. RALPH F. APODACA, V.CHM., N. MEX.

1. Automobile Insurance Sources.
2. Any other matter submitted for consideration.

9:00-10:15  
BALLROOM B

CIVIL DISORDERS - INSURANCE PROBLEMS 30  
(A7) COMMITTEE

HON. T. NELSON PARKER, CHM., VA.

HON. GEORGE M. COWDEN, V.CHM., TEXAS

1. Report of previous Meetings.  
New York, New York — 2/7/68  
Richmond, Virginia — 5/10/68
2. Any other matter submitted for consideration.

<i>TUES. A.M.</i>	<i>JUNE 18, 1968</i>	<i>MTG.</i>
9:00-10:15 BALLROOM A	FEDERAL LIAISON (C) COMMITTEE	31
	HON. RICHARD E. STEWART, CHM., N. Y.	
	HON. GEORGE M. COWDEN, V.CHM., TEXAS	
	1. Implementation of Hughes Panel Report.	
	2. S.E.C. Rule 10b-12	
	3. Automobile Insurance Studies.	
	4. Any other matter submitted for consideration.	
9:00-10:15 GALLERIA 2	ADVERTISING OF INSURANCE (H) COMMITTEE	32
	HON. FRANK R. MONTGOMERY, CHM., W. VA.	
	HON. ROBERT D. PRESTON, V.CHM., KY.	
	1. Any matter submitted for consideration.	
10:30-12:00 BALLROOM A	PLENARY SESSION - 1	33
	HON. JAMES L. BENTLEY, PRESIDENT - GEORGIA PRESIDING	
<i>TUES. P.M.</i>	<i>JUNE 18, 1968</i>	
	NO MEETING SCHEDULED - PUBLICATION OF REPORTS.	
<i>WED. A.M.</i>	<i>JUNE 19, 1968</i>	
9:00-10:15 BALLROOM A	LAWS AND LEGISLATION (D) COMMITTEE	34
	HON. RICHARD S. L. RODDIS, CHM., CALIF.	
	HON. C. EUGENE FARNAM, V.CHM., MASS.	
	1. To Prepare Model Legislation to Modify Schedule "P" Statutes (D1) Subcom. Report (Mtg. 4)	
	2. To Draft Model Legislation Relating to Insurance Holding Companies (D2) Subcom. Report (Mtg. 26)	
	3. To Make Recommendations, including drafting of Model Legislation if necessary, to Regulate Long Term Credit Insurance (D3) Subcom. Report (Mtg. 18)	
	4. To Make Recommendations, including drafting of Model Legislation if necessary, dealing with Unauthorized Insurers (D4) Subcom. Report (Mtg. 15)	
	5. To Study Procedures of Reorganization, Receivership and Liquidation (D5) Subcom. Report (Mtg. 16)	
	6. To Study Administration Experience of Proxy Regula- tions and Insider Trading Regulations and Make Recommendations (D6) Subcom. Report (Mtg. 22)	
	7. Presentation by Professor Lester B. Strickler, School of Business, Oregon State University Study of Premium Taxation.	
	8. Any other matter submitted for consideration.	
9:00-10:15 BALLROOM B	VALUATION OF SECURITIES (G) COMMITTEE	35
	HON. T. NELSON PARKER, CHM., VA.	
	HON. RICHARD E. STEWART, V.CHM., N. Y.	
	1. Valuation of Securities (G1) Subcom. Report (Mtg. 20)	
	2. Any other matter submitted for consideration.	

WED. A.M.

JUNE 19, 1968

MTG.

10:30-12:00  
BALLROOM B

EXAMINATIONS (B) COMMITTEE

36

HON. LEE I. KUECKELHAN, CHM., WASH.

HON. C. EUGENE FARNAM, V.CHM., MASS.

1. Examinations Manual Revision (B1) Subcom. Report (Mtg. 14)
2. Examinations of Accts. & Records by Electronic Computers (B2) Subcom. Report (Mtg. 25)
3. To Study Compensation System of Examinations (B3) Subcom. NMS
4. Association Examinations Procedure for Rating and Statistical Organizations (B4) Subcom. Report (Mtg. 9)
5. Current Reinsurance Practices.
6. Any other matter submitted for consideration.

10:30-12:00  
BALLROOM A

+PROPERTY, CASUALTY AND SURETY INSURANCE (F) COMMITTEE

+37

HON. DONALD KNOWLTON, CHM., N. H.

HON. BROWARD WILLIAMS, V.CHM., FLA.

1. Rates and Rating Organizations (F1) Subcom. Report (Mtg. 27)
2. Unauthorized Insurers (F2) Subcom. Report (Mtg. 24)
3. Hurricane-Flood and Related Insurance (F3) Subcom. Report (Mtg. 11)
4. Joint Industry Study of Mortgage Insurance Problems (F4) Subcom. Report (Mtg. 7)
5. Actuarial (F5) Subcom. Report (Mtg. 8)
6. To Consider Premium Financing by Insurers (F6) Subcom. Report (Mtg. 12)
- 7.+Additional Regulation of Special Property Coverages in connection with Installment Sales or Credit Transactions (F7) Subcom. Report (Mtg. 38) +38
8. To Study Regulations of Financial Guarantees (F8) Subcom. Report (Mtg. 19)
9. Definition and Interpretation of Underwriting Powers
  - (a) Classification of Fire, Marine and Casualty Insurance  
Industry Committee Report
  - (b) Interpretation of Nation-Wide Marine Definition  
Industry Committee Report
10. Aircraft Insurance — Policy Provisions and Underwriting.
11. Federal Crop Hail Insurance.
12. Any other matter submitted for consideration.

WED. P.M.

JUNE 19, 1968

1:30-2:45  
BALLROOM B

+BLANKS (A5) COMMITTEE

+39

HON. JAMES H. HUNT, CHM., VT.

HON. RICHARD S. L. RODDIS, V.CHM., CALIF.

1. BLANKS (A5) COMMITTEE Report (Meeting 3/25-27/68 — New York, N. Y.)
- 2.+Fire, Casualty and Reciprocal Blank (A5a) Subcom. Report (Mtg. 40) +40
3. To determine what steps should be taken to permit the separation of property coverage premiums from the homeowners and other comprehensive policies, to enable the insurance companies to report separately this coverage premium so as to provide for a proper assessment by state in the event a National Insurance Development Corporation is established. (Vermont)
4. Any other matter submitted for consideration.

<i>WED. P.M.</i>		<i>JUNE 19, 1968</i>		<i>MTG.</i>
1:30-2:45 BALLROOM A	LIFE, ACCIDENT AND HEALTH INSURANCE (E) COMMITTEE			41
	HON. BROWARD WILLIAMS, CHM., FLA. HON. T. NELSON PARKER, V.CHM., VA.			
	1. Accident and Health Insurance (E1) Subcom. Report (Mtg. 5) 2. Credit Life and Credit Accident & Health (E2) Subcom. Report (Mtg. 28) 3. Fraternal Insurance (E3) Subcom. NMS 4. Life Insurance (E4) Subcom. Report (Mtg. 10) 5. Non-Profit Hospital & Med. Service Assns. (E5) Subcom. Report (Mtg. 6) 6. Variable Annuities (E6) Subcom. Report (Mtg. 23) 7. Any other matter submitted for consideration.			
3:00-4:00	ZONE 1 - BA 42;	ZONE 2 - BB 43;	ZONE 3 - G2 44;	
4:00-5:00	ZONE 4 - BA 45;	ZONE 5 - BB 46;	ZONE 6 - G2 47	
<i>THUR. A.M.</i>		<i>JUNE 20, 1968</i>		
9:00-11:00 BALLROOM A	EXECUTIVE (A) COMMITTEE			48
	HON. NED PRICE, CHM., TEXAS HON. RICHARD S. L. RODDIS, V.CHM., CALIF.			
	EXECUTIVE (A) COMMITTEE Report (Special Meeting 3/11/68 — Jackson, Wyoming)			
	1. To Study Future Sites for NAIC Meetings (A1) Subcom. Report (Mtg. 17) 2. Uninsured and Partially Uninsured Non-Regulated Plans (A2) Subcom. Report (Mtg. 21) 3. To Study Reorganization and Public Information Matters (A3) Subcom. Report (Mtg. 13) 4. Liaison with State Agencies (A4) Subcom. Report (Mtg. 3) 5. BLANKS (A5) COMMITTEE Report (Mtg. 39) 6. MEXICO INSURANCE PROBLEMS (A6) COMMITTEE Report (Mtg. 29) 7. CIVIL DISORDERS — INSURANCE PROBLEMS (A7) COMMITTEE Report (Mtg. 30) 8. Audit Report of Executive Secretary's Office. 9. Executive Secretary's Report. 10. Selection of Executive Secretary. 11. Any other matter submitted for consideration.			
<i>THUR. P.M.</i>		<i>JUNE 20, 1968</i>		
2:00-4:00 BALLROOM A	PLENARY SESSION - 2			49
	HON. JAMES L. BENTLEY, PRESIDENT - GEORGIA PRESIDING			
<i>FRI. A.M.</i>		<i>JUNE 21, 1968</i>		
9:30-1:00 BALLROOM A	#PLENARY EXECUTIVE SESSION - 3			#50
	HON. JAMES L. BENTLEY, PRESIDENT - GEORGIA PRESIDING			
#EXECUTIVE SESSION +JOINT MEETING NMS - NO MEETING SCHEDULED MEETING ROOMS ON BALLROOM LEVEL - BA-BALLROOM A; BB-BALLROOM B; G2-GALLERIA 2; PC-PARLOR C; PE-PARLOR E.				
NEXT NAIC SCHEDULED MEETING — 1968 REGULAR MEETING Century Plaza Hotel, Hdqtrs. Los Angeles, California DECEMBER 1-6, 1968				

O F F I C E R S

<b>JAMES L. BENTLEY</b> Insurance Commissioner Atlanta, Georgia 30334	<b>PRESIDENT</b>
<b>CHARLES R. HOWELL</b> Commissioner of Insurance Trenton, New Jersey 08625	<b>VICE-PRESIDENT</b>
<b>RALPH F. APODACA</b> Superintendent of Insurance Santa Fe, New Mexico 87501	<b>SECRETARY-TREASURER</b>

COMMITTEES and Subcommittees

(A) EXECUTIVE COMMITTEE  
(NAIC Constitution ART. 6)

<b>NED PRICE, CHAIRMAN</b>		<b>TEXAS</b>
<b>RICHARD S. L. RODDIS,</b> <b>VICE CHAIRMAN</b>		<b>CALIFORNIA</b>
David J. Dykhouse		Michigan
Richard E. Stewart		New York
C. Eugene Farnam	Zone 1	Massachusetts
David O. Maxwell	Zone 2	Pennsylvania
Broward Williams	Zone 3	Florida
Robert D. Haase	Zone 4	Wisconsin
J. Richard Barnes	Zone 5	Colorado
Louis T. Mastos	Zone 6	Nevada
<b>JAMES L. BENTLEY, PRESIDENT</b>		<b>GEORGIA</b>
<b>CHARLES R. HOWELL,</b> <b>VICE PRESIDENT</b>		<b>NEW JERSEY</b>
<b>RALPH F. APODACA,</b> <b>SECRETARY-TREASURER</b>		<b>NEW MEXICO</b>

(A1) Subcommittee - To Study Future Sites for NAIC Meetings (12/51)

<b>J. Richard Barnes, Chairman</b>		<b>Colorado</b>
Broward Williams		Florida
Joseph G. Wood		Indiana
C. N. Ottosen		Utah
James H. Hunt		Vermont
T. Nelson Parker		Virginia

(A2) Subcommittee - Uninsured and Partially Uninsured Non-Regulated Plans (6/63)

<b>J. Richard Barnes, Chairman</b>		<b>Colorado</b>
<b>Robert D. Haase, Vice Chairman</b>		<b>Wisconsin</b>
Robert D. Preston		Kentucky
C. Eugene Farnam		Massachusetts
T. Nelson Parker		Virginia

## (A3) Subcommittee - To Study Reorganization and Public Information Matters (10/64)

T. Nelson Parker, Chairman	Virginia
Richard E. Stewart, Vice Chairman	New York
Richard S. L. Roddis	California
J. Richard Barnes	Colorado
James L. Bentley	Georgia
Lorne R. Worthington	Iowa
C. Eugene Farnam	Massachusetts
Walter D. Davis	Mississippi
Donald Knowlton	New Hampshire
Charles R. Howell	New Jersey
Lee I. Kueckelhan	Washington

## (A4) Subcommittee - Liaison with State Agencies (12/67)

David O. Maxwell, Chairman	Pennsylvania
Benjamin C. Neff, Jr., Vice Chairman	Nebraska
Dudley A. Guglielmo	Louisiana
Thomas C. Hunt	Minnesota
Donald Knowlton	New Hampshire
James R. Faulstich	Oregon

(A5) BLANKS COMMITTEE  
(Standing Committee)  
(Reports to Executive Committee)  
(NAIC By-Laws SECTION 5)

JAMES H. HUNT, CHAIRMAN	VERMONT
RICHARD S. L. RODDIS, VICE CHAIRMAN	CALIFORNIA
Jerry P. Shea	Arizona
Broward Williams	Florida
James L. Bentley	Georgia
Joseph G. Wood	Indiana
Frank Sullivan	Kansas
Robert D. Preston	Kentucky
David J. Dykhouse	Michigan
Robert D. Scharz	Missouri
Benjamin C. Neff, Jr.	Nebraska
Charles R. Howell	New Jersey
Richard E. Stewart	New York
David O. Maxwell	Pennsylvania
David M. Pack	Tennessee
Clay Cotten	Texas
T. Nelson Parker	Virginia
Lee I. Kueckelhan	Washington
Robert D. Haase	Wisconsin

## Subcommittees - BLANKS COMMITTEE

## Conflict of Interest

W. Harold Bittel, Chm.	N. J.	Walter J. Madden	Nebr.
Christy P. Armstrong	Calif.	William C. Gould	N. Y.
Ernest J. Meredith	Md.	E. J. Voorhis, Jr.	Texas

## Fire, Casualty and Reciprocal Blank Subcommittee

William C. Gould, Chm.	N. Y.	George F. Howarth	Mass.
E. J. Voorhis, Jr., V.Chm.	Texas	Robert A. Bailey	Mich.
Christy P. Armstrong	Calif.	Robert E. Holliday	Mo.
Charles A. Spoerl	Conn.	Walter J. Madden	Nebr.
Frank de Veer	Fla.	W. Harold Bittel	N. J.
T. Donald Karnes	Ill.	Richard W. Krimm	Pa.
Everett Westbrook	Ind.	Francis T. McGovern	R. I.
Robert B. Evans	Ky.	John W. Washington	Tenn.
Sidney O. Robertson	La.	Woodrow W. Paris	Va.
Ernest J. Meredith	Md.	Donald D. Bower	Wash.

Life, Accident and Health Blank Subcommittee

W. Harold Bittel, Chm.	N. J.	J. Arthur Wedgeworth	Mass.
M. Dean Frash	Ariz.	William C. Conley	Mich.
Christy P. Armstrong	Calif.	Robert E. Holliday	Mo.
Lloyd J. Engstrom	Colo.	Walter J. Madden	Nebr.
Charles A. Spoerl	Conn.	I. Murray Krowitz	N. Y.
Frank de Veer	Fla.	Richard W. Krimm	Pa.
Herbert B. Sturtevant	Ga.	Francis T. McGovern	R. I.
T. Donald Karnes	Ill.	Henry G. Eggert	Tenn.
Everett Westbrook	Ind.	E. J. Voorhis, Jr.	Texas
Robert B. Evans	Ky.	John H. Parker	Va.
Sidney O. Robertson	La.	Donald D. Bower	Wash.
Ernest J. Meredith	Md.		

Fraternal Blank Subcommittee

Francis T. McGovern, Chm.	R. I.	Walter J. Madden	Nebr.
Christy P. Armstrong	Calif.	Thomas J. Kelly	N. Y.
Bernard Risse	Ill.	Richard W. Krimm	Pa.
Everett Westbrook	Ind.	Donald D. Bower	Wash.
George F. Howarth	Mass.		

Hospital and Medical Service Plans Blank Subcommittee

George F. Howarth, Chm.	Mass.	William C. Gould	N. Y.
William C. Conley	Mich.	Richard W. Krimm	Pa.
Walter J. Madden	Nebr.	Francis T. McGovern	R. I.
W. Harold Bittel	N. J.		

Title Insurance Blank Subcommittee

William C. Gould, Chm.	N. Y.	W. Harold Bittel	N. J.
Christy P. Armstrong	Calif.	Richard W. Krimm	Pa.
George F. Howarth	Mass.	E. J. Voorhis, Jr.	Texas
Robert A. Bailey	Mich.	Donald Bower	Wash.
Walter J. Madden	Nebr.		

Revision of Statement for Separate Account Business Subcommittee

W. Harold Bittel, Chm.	N. J.	I. Murray Krowitz	N. Y.
Francis C. Jumonville	La.		

To Consider Procedures for Handling Stock Options in Life, Accident and Health Blanks Subcommittee

W. Harold Bittel, Chm.	N. J.	Charles A. Spoerl	Conn.
Christy P. Armstrong	Calif.	George K. Bernstein	N. Y.

To Study Terminology Proposals Blanks Subcommittee

W. Harold Bittel, Chm.	N. J.	Walter J. Madden	Nebr.
Christy P. Armstrong	Calif.	I. Murray Krowitz	N. Y.
J. Arthur Wedgeworth	Mass.	E. J. Voorhis, Jr.	Texas

Instructions for Accounting for Medicare Service Contracts

Christy P. Armstrong, Chm.	Calif.	W. Harold Bittel	N. J.
Peter F. Kelly	Conn.	William C. Gould	N. Y.
Walter J. Madden	Nebr.		

To Prepare Uniform Page for Annual Statement Blank to be Used by States in Preparation of Annual Reports of Commissioners of Each State

Christy P. Armstrong, Chm.	Calif.	W. Harold Bittel	N. J.
Charles A. Spoerl	Conn.	William C. Gould	N. Y.
Robert A. Bailey	Mich.		

To Study Reporting of "Adjusted Earnings" by Life Companies

John W. Riley, Chm.	Ky.	James H. Hunt	Vt.
Lorne R. Worthington	Iowa	Robert D. Haase	Wis.
Thomas J. Kelly	N. Y.		

(A6) MEXICO INSURANCE PROBLEMS COMMITTEE  
(Reports to Executive Committee)  
(Special Committee 4/66)

WALTER S. HOUSEAL, CHAIRMAN	ALABAMA
RALPH F. APODACA, VICE CHAIRMAN	NEW MEXICO
Jerry P. Shea	Arizona
Richard S. L. Roddis	California
J. Richard Barnes	Colorado
Dudley A. Guglielmo	Louisiana
Louis T. Mastos	Nevada
Clay Cotten	Texas

(A7) CIVIL DISORDERS - INSURANCE PROBLEMS COMMITTEE  
(Reports to Executive Committee)  
(Special Committee 8/67)

T. NELSON PARKER, CHAIRMAN	VIRGINIA
GEORGE M. COWDEN, VICE CHAIRMAN	TEXAS
Richard S. L. Roddis	California
John F. Bolton, Jr.	Illinois
David J. Dykhous	Michigan
Richard E. Stewart	New York
Eugene P. Brown	Ohio

(B) EXAMINATIONS COMMITTEE  
(NAIC Constitution ART. 6)

LEE I. KUECKELHAN, CHAIRMAN	ZONE 6	WASHINGTON
C. EUGENE FARNAM, VICE CHAIRMAN	ZONE 1	MASSACHUSETTS
Frank R. Montgomery	Zone 2	West Virginia
David M. Paek	Zone 3	Tennessee
John F. Bolton, Jr.	Zone 4	Illinois
William G. Walton	Zone 5	Wyoming

(B1) Subcommittee - Examinations Manual Revision (6/57)

Richard S. L. Roddis, Chairman	California
John F. Bolton, Jr., Vice Chairman	Illinois
William R. Cotter	Connecticut
Dudley A. Guglielmo	Louisiana
David J. Dykhous	Michigan
Eugene P. Brown	Ohio
Clay Cotten	Texas

(B2) Subcommittee - Examinations of Accounts and Records Compiled by  
Electronic Computers (12/61)

Richard S. L. Roddis, Chairman	California
Lorne R. Worthington by Richard S. Baldwin	Iowa
Newton I. Steers, Jr. by Ernest J. Meredith	Maryland
C. Eugene Farnam by George F. Howarth	Massachusetts
Benjamin C. Neff, Jr. by Walter J. Madden	Nebraska
Richard E. Stewart by William C. Gould	New York
Edwin S. Lanier by George E. King	North Carolina
Clay Cotten by E. J. Voorhis, Jr.	Texas



(B3) Subcommittee - To Study Compensation System of Examinations (12/62)

Louis T. Mastos, Chairman	Nevada
T. Nelson Parker	Virginia

(B4) Subcommittee - Association Examinations Procedure for Rating and Statistical Organizations (12/66)

Richard E. Stewart, Chairman by Alexander E. Fox	New York
Richard S. L. Roddis by Mark Kai-Kee	California
William R. Cotter by Robert A. Brian	Connecticut
Broward Williams	Florida
John F. Bolton, Jr. by Phil Williams	Illinois
Robert D. Haase by Martin F. Raynoha	Wisconsin

(C) FEDERAL LIAISON COMMITTEE  
(Standing Committee)

RICHARD E. STEWART, CHAIRMAN	NEW YORK
GEORGE M. COWDEN, VICE CHAIRMAN	TEXAS
Richard S. L. Roddis	California
William R. Cotter	Connecticut
Broward Williams	Florida
James L. Bentley	Georgia
John F. Bolton, Jr.	Illinois
Lorne R. Worthington	Iowa
Newton I. Steers, Jr.	Maryland
C. Eugene Farnam	Massachusetts
David J. Dykhous	Michigan
Walter D. Davis	Mississippi
Benjamin C. Neff, Jr.	Nebraska
Donald Knowlton	New Hampshire
Charles R. Howell	New Jersey
Eugene P. Brown	Ohio
T. Nelson Parker	Virginia
Lee I. Kueckelhan	Washington
William G. Walton	Wyoming

(D) LAWS AND LEGISLATION COMMITTEE  
(Standing Committee)

RICHARD S. L. RODDIS, CHAIRMAN	CALIFORNIA
C. EUGENE FARNAM, VICE CHAIRMAN	MASSACHUSETTS
Allan W. Horne	Arkansas
John F. Bolton, Jr.	Illinois
Lorne R. Worthington	Iowa
Robert D. Preston	Kentucky
David J. Dykhous	Michigan
Thomas C. Hunt	Minnesota
Walter D. Davis	Mississippi
Benjamin C. Neff, Jr.	Nebraska
Louis T. Mastos	Nevada
Donald Knowlton	New Hampshire
Ralph F. Apodaca	New Mexico
Richard E. Stewart	New York
James R. Faulstich	Oregon
David O. Maxwell	Pennsylvania
Warren E. Dirks	South Dakota
David M. Pack	Tennessee
Durwood Manford	Texas
C. N. Ottosen	Utah
Frank R. Montgomery	West Virginia
Robert D. Haase	Wisconsin
William G. Walton	Wyoming

## (D1) Subcommittee - To Prepare Model Legislation to Modify Schedule "P" Statutes (12/63)

David J. Dykhouse, Chairman	Michigan
John F. Bolton, Jr.	Illinois
Charles R. Howell	New Jersey
Charles W. Gambrell	South Carolina
Frank R. Montgomery	West Virginia

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## (D2) Subcommittee - To Draft Model Legislation Relating to Insurance Holding Companies (6/67)

Benjamin C. Neff, Jr., Chairman	Nebraska
Robert A. Short	Delaware
Lorne R. Worthington	Iowa
Frank M. Hogerty, Jr.	Maine
C. Eugene Farnam	Massachusetts
Richard E. Stewart	New York
Edwin S. Lanier	North Carolina
James R. Faulstich	Oregon
David O. Maxwell	Pennsylvania
Warren E. Dirks	South Dakota
Durwood Manford	Texas

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## (D3) Subcommittee - To Make Recommendations, including drafting of Model Legislation if necessary, to Regulate Long Term Credit Insurance (6/67)

William G. Walton, Chairman	Wyoming
Allan W. Horne	Arkansas
J. Richard Barnes	Colorado
Newton I. Steers, Jr.	Maryland
David J. Dykhouse	Michigan
Benjamin C. Neff, Jr.	Nebraska
James H. Hunt	Vermont
Lee I. Kueckelhan	Washington

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## (D4) Subcommittee - To Make Recommendations, including drafting of Model Legislation if necessary, dealing with Unauthorized Insurers (6/67)

James R. Faulstich, Chairman	Oregon
Frank M. Hogerty, Jr.	Maine
Thomas C. Hunt	Minnesota
Donald Knowlton	New Hampshire
Edwin S. Lanier	North Carolina
David O. Maxwell	Pennsylvania
Durwood Manford	Texas
Robert D. Haase	Wisconsin

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## (D5) Subcommittee - To Study Procedures of Reorganization, Receivership and Liquidation (6/67)

John F. Bolton, Jr., Chairman	Illinois
Benjamin C. Neff, Jr.	Nebraska
Louis T. Mastos	Nevada
David M. Paek	Tennessee
Durwood Manford	Texas
Robert D. Haase	Wisconsin

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(D6) Subcommittee - To Study Administration Experience of the Proxy Regulations and the Insider Trading Regulations and Consider Suggested Revisions (12/67)

David O. Maxwell, Chairman	Pennsylvania
Lorne R. Worthington	Iowa
Thomas C. Hunt	Minnesota
Benjamin C. Neff, Jr.	Nebraska
Richard E. Stewart	New York

(E) LIFE, ACCIDENT AND HEALTH INSURANCE COMMITTEE  
(Standing Committee)

BROWARD WILLIAMS, CHAIRMAN	FLORIDA
T. NELSON PARKER, VICE CHAIRMAN	VIRGINIA
Walter S. Houseal	Alabama
Jerry P. Shea	Arizona
Richard S. L. Roddis	California
J. Richard Barnes	Colorado
Robert A. Short	Delaware
Albert F. Jordan	Dist. of Columbia
James L. Bentley	Georgia
Joseph G. Wood	Indiana
Dudley A. Guglielmo	Louisiana
David J. Dykhouse	Michigan
Thomas C. Hunt	Minnesota
Robert D. Scharz	Missouri
Benjamin C. Neff, Jr.	Nebraska
Charles R. Howell	New Jersey
Richard E. Stewart	New York
K. O. Nygaard	North Dakota
Eugene P. Brown	Ohio
Joe B. Hunt	Oklahoma
James R. Faulstich	Oregon
Julio R. Hernandez	Puerto Rico
James H. Hunt	Vermont
Robert D. Haase	Wisconsin

(E1) Subcommittee - Accident and Health Insurance

Dudley A. Guglielmo, Chairman	Louisiana
Durwood Manford, Vice Chairman	Texas
Jerry P. Shea	Arizona
Joseph G. Wood	Indiana
Robert D. Preston	Kentucky
Benjamin C. Neff, Jr.	Nebraska
Charles R. Howell	New Jersey
Edwin S. Lanier	North Carolina
Joe B. Hunt	Oklahoma
James R. Faulstich	Oregon
Robert D. Haase	Wisconsin

**(E2) Subcommittee - Credit Life and Credit Accident and Health Insurance**

Louis T. Mastos, Chairman	Nevada
Robert A. Short, Vice Chairman	Delaware
Walter S. Houseal	Alabama
J. Richard Barnes	Colorado
Broward Williams	Florida
Lorne R. Worthington	Iowa
David J. Dykhouse	Michigan
Robert D. Scharz	Missouri
Charles R. Howell	New Jersey
James R. Faulstich	Oregon
Charles W. Gambrell	South Carolina
James H. Hunt	Vermont
Frank R. Montgomery	West Virginia

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**(E2a) Subcommittee - Special Task Force to Study Mortality and Morbidity Experience of Credit Life and Credit Accident and Health Insurance (9/67)**

Louis T. Mastos, Chairman	Nevada
Robert A. Short, Vice Chairman	Delaware
Walter S. Houseal	Alabama
Broward Williams	Florida
Robert D. Scharz	Missouri
Charles R. Howell	New Jersey
James H. Hunt	Vermont

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**(E3) Subcommittee - Fraternal Insurance**

George M. Cowden, Chairman	Texas
Joseph G. Wood, Vice Chairman	Indiana
Jerry P. Shea	Arizona
Albert F. Jordan	Dist. of Columbia
Frank Sullivan	Kansas
Robert D. Scharz	Missouri
Ralph F. Apodaca	New Mexico
K. O. Nygaard	North Dakota
Julio R. Hernandez	Puerto Rico
Frank R. Montgomery	West Virginia
Robert D. Haase	Wisconsin
William G. Walton	Wyoming

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**(E4) Subcommittee - Life Insurance**

Frank R. Montgomery, Chairman	West Virginia
Robert D. Scharz, Vice Chairman	Missouri
Walter S. Houseal	Alabama
Albert F. Jordan	Dist. of Columbia
John F. Bolton, Jr.	Illinois
Thomas C. Hunt	Minnesota
Elmer V. Omholt	Montana
Richard E. Stewart	New York
James R. Faulstich	Oregon
Julio R. Hernandez	Puerto Rico
Durwood Manford	Texas
Robert D. Haase	Wisconsin

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(E5) Subcommittee - Non-Profit Hospital and Medical Service Associations

Lorne R. Worthington, Chairman	Iowa
Broward Williams, Vice Chairman	Florida
Walter S. Houseal	Alabama
Richard S. L. Roddis	California
Robert A. Short	Delaware
John R. Blaine	Idaho
Joseph G. Wood	Indiana
Dudley A. Guglielmo	Louisiana
Thomas C. Hunt	Minnesota
Louis T. Mastos	Nevada
Julio R. Hernandez	Puerto Rico
Clay Cotten	Texas

(E6) Subcommittee - Variable Annuities

Robert D. Haase, Chairman	Wisconsin
James H. Hunt, Vice Chairman	Vermont
Richard S. L. Roddis	California
J. Richard Barnes	Colorado
Albert F. Jordan	Dist. of Columbia
Broward Williams	Florida
Lorne R. Worthington	Iowa
Robert D. Preston	Kentucky
C. Eugene Farnam	Massachusetts
David J. Dykhous	Michigan
Charles R. Howell	New Jersey
Richard E. Stewart	New York

(F) PROPERTY, CASUALTY AND SURETY INSURANCE COMMITTEE  
(Standing Committee)

DONALD KNOWLTON, CHAIRMAN	NEW HAMPSHIRE
BROWARD WILLIAMS, VICE CHAIRMAN	FLORIDA
Walter S. Houseal	Alabama
Richard S. L. Roddis	California
J. Richard Barnes	Colorado
James L. Bentley	Georgia
Edwin H. Honda	Hawaii
John R. Blaine	Idaho
Lorne R. Worthington	Iowa
Dudley A. Guglielmo	Louisiana
David J. Dykhous	Michigan
Thomas C. Hunt	Minnesota
Robert D. Scharz	Missouri
Elmer V. Omholt	Montana
Richard E. Stewart	New York
Edwin S. Lanier	North Carolina
Charles W. Gambrell	South Carolina
Warren E. Dirks	South Dakota
Ned Price	Texas
Frank R. Montgomery	West Virginia
Robert D. Haase	Wisconsin

## (F1) Subcommittee - Rates and Rating Organizations

Robert D. Haase, Chairman	Wisconsin
Richard S. L. Roddis, Vice Chairman	California
Broward Williams	Florida
Lorne R. Worthington	Iowa
Dudley A. Guglielmo	Louisiana
Louis T. Mastos	Nevada
Donald Knowlton	New Hampshire
Richard E. Stewart	New York
Eugene P. Brown	Ohio
Ned Price	Texas
T. Nelson Parker	Virginia

## (F1a) Subcommittee - To Review Statistical Plans (12/64)

Robert D. Haase, Chairman by Stanley C. Du Rose	Wisconsin
Broward Williams by Samuel Rogers	Florida
Lorne R. Worthington by E. Arnold Smith	Iowa
David J. Dykhouse by William H. Larsen	Michigan
Charles R. Howell by Horace J. Bryant, Jr.	New Jersey
Richard E. Stewart by Jacob Malmuth	New York
Eugene P. Brown	Ohio
Lee I. Kueckelhan by William D. Yerkes	Washington

## (F2) Subcommittee - Unauthorized Insurers

Donald Knowlton, Chairman	New Hampshire
Broward Williams, Vice Chairman	Florida
Richard S. L. Roddis	California
J. Richard Barnes	Colorado
John F. Bolton, Jr.	Illinois
Dudley A. Guglielmo	Louisiana
Frank M. Hogerty, Jr.	Maine
Richard E. Stewart	New York
David O. Maxwell	Pennsylvania

## (F3) Subcommittee - Hurricane-Flood and Related Insurance Coverages (12/63)

Broward Williams, Chairman	Florida
Charles R. Howell, Vice Chairman	New Jersey
Richard S. L. Roddis	California
John F. Bolton, Jr.	Illinois
Dudley A. Guglielmo	Louisiana
Frank M. Hogerty, Jr.	Maine
Charles W. Gambrell	South Carolina
Ned Price	Texas

## (F3a) Subcommittee - Federal Government Flood Program (6/65)

Charles R. Howell, Chairman	New Jersey
Broward Williams	Florida
Ned Price	Texas

(F4) Subcommittee - Joint Industry Study of Mortgage Insurance Problems (11/65)

Richard E. Stewart, Chairman	New York
James L. Bentley	Georgia
Frank M. Hogerty, Jr.	Maine
Donald Knowlton	New Hampshire
Eugene P. Brown	Ohio
Robert D. Haase	Wisconsin

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(F5) Subcommittee - Actuarial (12/65)

David J. Dykhouse, Chairman by Robert A. Bailey	Michigan
Richard S. L. Roddis, Vice Chairman by Christy P. Armstrong	California
John F. Bolton, Jr. by T. Donald Karnes	Illinois
Charles R. Howell by W. Harold Bittel	New Jersey
Richard E. Stewart by Frank Harwayne	New York
Clay Cotten by Angus McDonald	Texas
T. Nelson Parker by John S. Jones	Virginia
Robert D. Haase by Stanley C. Du Rose	Wisconsin

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(F6) Subcommittee - To Consider Premium Financing by Insurers (6/67)

J. Richard Barnes, Chairman	Colorado
John R. Blaine	Idaho
Newton I. Steers, Jr.	Maryland
David J. Dykhouse	Michigan
Edwin S. Lanier	North Carolina

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(F7) Subcommittee - Additional Regulation of Special Property Coverages in Connection with Installment Sales or Credit Transactions (12/67)

J. Richard Barnes, Chairman	Colorado
John R. Blaine	Idaho
Newton I. Steers, Jr.	Maryland
David J. Dykhouse	Michigan
Edwin S. Lanier	North Carolina

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(F8) Subcommittee - To Study Regulations of Financial Guarantees (12/67)

Richard S. L. Roddis, Chairman	California
Lorne R. Worthington	Iowa
Newton I. Steers, Jr.	Maryland
Elmer V. Omholt	Montana
Edwin S. Lanier	North Carolina

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(G) VALUATION OF SECURITIES COMMITTEE  
(Standing Committee)

T. NELSON PARKER, CHAIRMAN	VIRGINIA
RICHARD E. STEWART, VICE CHAIRMAN	NEW YORK
William R. Cotter	Connecticut
Robert A. Short	Delaware
Broward Williams	Florida
James L. Bentley	Georgia
John R. Blaine	Idaho
John F. Bolton, Jr.	Illinois
Joseph G. Wood	Indiana
Dudley A. Guglielmo	Louisiana
C. Eugene Farnam	Massachusetts
Elmer V. Ombolt	Montana
Benjamin C. Neff, Jr.	Nebraska
Louis T. Mastos	Nevada
Charles R. Howell	New Jersey
Eugene P. Brown	Ohio
Joe B. Hunt	Oklahoma
David O. Maxwell	Pennsylvania
Ralph A. Petrarca	Rhode Island
Warren E. Dirks	South Dakota
David M. Pack	Tennessee
Clay Cotten	Texas
Lee I. Kueckelhan	Washington

## (G1) Subcommittee - Valuation of Securities

Richard E. Stewart, Chairman	New York
Joseph G. Wood, Vice Chairman	Indiana
William R. Cotter	Connecticut
Broward Williams	Florida
John F. Bolton, Jr.	Illinois
C. Eugene Farnam	Massachusetts
Benjamin C. Neff, Jr.	Nebraska
Louis T. Mastos	Nevada
Charles R. Howell	New Jersey
Eugene P. Brown	Ohio
David O. Maxwell	Pennsylvania
T. Nelson Parker	Virginia

(H) ADVERTISING OF INSURANCE COMMITTEE  
(Special Committee)

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ROBERT D. PRESTON, VICE CHAIRMAN	KENTUCKY
Jerry P. Shea	Arizona
Allan W. Horne	Arkansas
Broward Williams	Florida
Edwin H. Honda	Hawaii
John R. Blaine	Idaho
Frank Sullivan	Kansas
Robert D. Scharz	Missouri
Elmer V. Ombolt	Montana
Louis T. Mastos	Nevada
Edwin S. Lanier	North Carolina
K. O. Nygaard	North Dakota
David O. Maxwell	Pennsylvania
Ralph A. Petrarca	Rhode Island
Charles W. Gambrell	South Carolina
C. N. Ottosen	Utah
William G. Walton	Wyoming



## NAIC ZONES

### ZONE I

\*+C. EUGENE FARNAM,  
CHAIRMAN  
Commissioner of Insurance  
Boston, Massachusetts 02202

MASS.

William R. Cotter  
Frank M. Hogerty, Jr.  
Donald Knowlton  
Charles R. Howell  
Richard E. Stewart  
Ralph A. Petrarca  
James H. Hunt  
Cyril E. King

Conn.  
Maine  
N. H.  
N. J.  
N. Y.  
R. I.  
Vt.  
V. I.

### ZONE II

+FRANK B. MONTGOMERY,  
CHAIRMAN  
Insurance Commissioner  
Charleston, West Virginia 25305

W. VA.

Robert A. Short  
Albert F. Jordan  
Newton I. Steers, Jr.  
Edwin S. Lanier  
Eugene P. Brown  
\*David O. Maxwell  
Charles W. Gambrell  
T. Nelson Parker

Del.  
D. C.  
Md.  
N. C.  
Ohio  
Pa.  
S. C.  
Va.

### ZONE III

+DAVID M. PACK,  
CHAIRMAN  
Commissioner of Insurance  
Nashville, Tennessee 37219

TENN.

Walter S. Houseal  
\*Broward Williams  
James L. Bentley  
Robert D. Preston  
Dudley A. Guglielmo  
Walter D. Davis  
Robert D. Scharz  
Julio R. Hernandez

Ala.  
Fla.  
Ga.  
Ky.  
La.  
Miss.  
Mo.  
P. R.

### ZONE IV

+JOHN F. BOLTON, JR.,  
CHAIRMAN  
Director of Insurance  
160 N. LaSalle St. - Room 1600  
Chicago, Illinois 60601

ILL.

Joseph G. Wood  
Lorne R. Worthington  
David J. Dykhouse  
Thomas C. Hunt  
K. O. Nygaard  
Warren E. Dirks  
\*Robert D. Haase

Ind.  
Iowa  
Mich.  
Minn.  
N. D.  
S. D.  
Wis.

### ZONE V

+WILLIAM G. WALTON,  
CHAIRMAN  
Insurance Commissioner  
Cheyenne, Wyoming 82001

WYO.

Allan W. Horne  
\*J. Richard Barnes  
Frank Sullivan  
Benjamin C. Neff, Jr.  
Ralph F. Apodaca  
Joe B. Hunt  
Clay Cotten  
Ned Price  
Durwood Manford  
George M. Cowden

Ark.  
Colo.  
Kansas  
Nebr.  
N. Mex.  
Okla.  
Texas  
Texas  
Texas  
Texas

### ZONE VI

+LEE I. KUECKELHAN,  
CHAIRMAN  
Insurance Commissioner  
Olympia, Washington 98501

WASH.

W. W. Fritz  
Jerry P. Shea  
Richard S. L. Roddis  
Joaquin C. Guerrero  
Edwin H. Honda  
John R. Blaine  
Elmer V. Omholt  
\*Louis T. Mastos  
James R. Faulstich  
C. N. Ottosen

Alaska  
Ariz.  
Calif.  
Guam  
Hawaii  
Idaho  
Mont.  
Nev.  
Ore.  
Utah

\*EXECUTIVE COMMITTEE Members Elected by Zones — NAIC Const. ART. 6

+EXAMINATIONS COMMITTEE Members Elected by Zones — NAIC Const. ART. 6

## MEMBERS of the NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

ALA.	Walter S. Houseal	Superintendent of Insurance	Montgomery 36104
ALASKA	W. W. Fritz	Director of Insurance	Juneau 99801
ARIZ.	Jerry P. Shea	Director of Insurance	Phoenix 85011
ARK.	Allan W. Horne	Insurance Commissioner	Little Rock 72201
CALIF.	Richard S. L. Roddis	Insurance Commissioner	San Francisco 94108
COLO.	J. Richard Barnes	Commissioner of Insurance	Denver 80203
CONN.	William R. Cotter	Insurance Commissioner	Hartford 06115
DEL.	Robert A. Short	Insurance Commissioner	Dover 19901
D. C.	Albert F. Jordan	Superintendent of Insurance	Washington 20036
FLA.	Broward Williams	Insurance Commissioner	Tallahassee 32304
GA.	James L. Bentley	Insurance Commissioner	Atlanta 30334
GUAM	Joaquin C. Guerrero	Insurance Commissioner	Agana 96910
HAWAII	Edwin H. Honda	Insurance Commissioner	Honolulu 96813
IDAHO	John R. Blaine	Commissioner of Insurance	Boise 83707
ILL.	John F. Bolton, Jr.	Director of Insurance	Springfield 62706
IND.	Joseph G. Wood	Commissioner of Insurance	Indianapolis 46204
IOWA	Lorne R. Worthington	Commissioner of Insurance	Des Moines 50819
KANSAS	Frank Sullivan	Commissioner of Insurance	Topeka 66612
KY.	Robert D. Preston	Commissioner of Insurance	Frankfort 40601
LA.	Dudley A. Guglielmo	Commissioner of Insurance	Baton Rouge 70804
MAINE	Frank M. Hogerty, Jr.	Insurance Commissioner	Augusta 04330
MD.	Newton I. Steers, Jr.	Insurance Commissioner	Baltimore 21201
MASS.	C. Eugene Farnam	Commissioner of Insurance	Boston 02202
MICH.	David J. Dykhouse	Commissioner of Insurance	Lansing 48913
MINN.	Thomas C. Hunt	Commissioner of Insurance	St. Paul 55101
MISS.	Walter D. Davis	Commissioner of Insurance	Jackson 39205
MO.	Robert D. Scharz	Superintendent of Insurance	Jefferson City 65101
MONT.	Eimer V. Ombolt	Commissioner of Insurance	Helena 59601
NEBR.	Benjamin C. Neff, Jr.	Director of Insurance	Lincoln 68509
NEV.	Louis T. Mastos	Commissioner of Insurance	Carson City 89701
N. H.	Donald Knowlton	Insurance Commissioner	Concord 03301
N. J.	Charles R. Howell	Commissioner of Insurance	Trenton 08625
N. MEX.	Ralph F. Apodaca	Superintendent of Insurance	Santa Fe 87501
N. Y.	Richard E. Stewart	Superintendent of Insurance	New York 10038
N. C.	Edwin S. Lanier	Commissioner of Insurance	Raleigh 27602
N. D.	K. O. Nygaard	Commissioner of Insurance	Bismarck 58501
OHIO	Eugene P. Brown	Director of Insurance	Columbus 43215
OKLA.	Joe B. Hunt	Insurance Commissioner	Oklahoma City 73105
ORE.	James R. Faulstich	Insurance Commissioner	Salem 97310
PA.	David O. Maxwell	Insurance Commissioner	Harrisburg 17120
P. R.	Julio R. Hernandez	Commissioner of Insurance	Santurce 00910
R. I.	Ralph A. Petrarca	Insurance Commissioner	Providence 02903
S. C.	Charles W. Gambrell	Insurance Commissioner	Columbia 29201
S. D.	Warren E. Dirks	Commissioner of Insurance	Pierre 57501
TENN.	David M. Pack	Commissioner of Insurance	Nashville 37219
TEXAS	Clay Cotten	Commissioner of Insurance	Austin 78701
TEXAS	Ned Price	State Board of Insurance	Austin 78701
TEXAS	Durwood Manford	State Board of Insurance	Austin 78701
TEXAS	George M. Cowden	State Board of Insurance	Austin 78701
UTAH	C. N. Ottosen	Commissioner of Insurance	Salt Lake City 84114
VT.	James H. Hunt	Commissioner of Insurance	Montpelier 05602
V. I.	Cyril E. King	Commissioner of Insurance	St. Thomas 00801
VA.	T. Nelson Parker	Commissioner of Insurance	Richmond 23209
WASH.	Lee I. Kueckelhan	Insurance Commissioner	Olympia 98501
W. VA.	Frank R. Montgomery	Insurance Commissioner	Charleston 25305
WIS.	Robert D. Haase	Commissioner of Insurance	Madison 53702
WYO.	William G. Walton	Insurance Commissioner	Cheyenne 82001

Provinces of Canada, Republic of Philippines and Mexico are Honorary Members.



HON. EUGENE P. BROWN  
DIRECTOR OF INSURANCE  
STATE OF OHIO

HON. JULIO R. HERNANDEZ  
COMMISSIONER OF INSURANCE  
COMMONWEALTH OF PUERTO RICO  
(In office prior to last Meeting but introduction was erroneously omitted.)

HON. RALPH A. PETRARCA  
INSURANCE COMMISSIONER  
STATE OF RHODE ISLAND  
(In office prior to last Meeting but was unable to attend.)

HON. GEORGE M. COWDEN  
CHAIRMAN - STATE BOARD OF INSURANCE  
STATE OF TEXAS

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8. ROLL CALL  
HON. RALPH F. APODACA  
SUPERINTENDENT OF INSURANCE  
STATE OF NEW MEXICO  
SECRETARY-TREASURER OF NAIC

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9. PRESIDENT'S REPORT  
HON. JAMES L. BENTLEY  
INSURANCE COMMISSIONER  
STATE OF GEORGIA  
PRESIDENT OF NAIC

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10. APPOINT RESOLUTIONS  
COMMITTEE  
HON. \_\_\_\_\_  
HON. \_\_\_\_\_  
HON. \_\_\_\_\_  
HON. \_\_\_\_\_  
HON. \_\_\_\_\_

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11. ANNOUNCEMENTS (if any)

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12. ADJOURNMENT - PLENARY SESSION - 1

NOTE: Before adjourning, you may wish to announce that PLENARY SESSION - 2 (MTG. 49) will convene in this ROOM (BALLROOM A) THURSDAY, JUNE 20, 1968 at 2:00 P.M. to consider:

(A) COMMITTEE REPORTS

Discuss and RECEIVE (or ADOPT if not controversial)  
REPORTS of COMMITTEES.

(B) Any other matter submitted for NAIC consideration.

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END OF PLENARY SESSION - 1

## PLENARY SESSION - 1

The first Plenary Session of the 1968 Annual Meeting was called to order in Ballroom A of the Portland Hilton Hotel on June 18, Hon. James L. Bentley, President, presiding.

**PRESIDENT BENTLEY:** The First Plenary Session of the 1968 Annual Meeting of the National Association of Insurance Commissioners is hereby called to order. I will appoint John Coppage of Maryland and Ben Franklin of Louisiana as Sergeants-at-Arms for this convention.

To deliver the invocation this morning, we have with us Dr. Paul S. Wright of the First Presbyterian Church of Portland, Oregon. Dr. Wright.

**DR. WRIGHT:** Let us pray. O God, we invoke thy Divine Presence and thy blessing upon this convention. We acknowledge thy Fatherly rule in the universe and in the lives of men to be good, the source of justice, of righteousness, of love and community. We bless Thee for thy care of us and for this care Thou hast put into our hearts for one another, that Thy spirit hast guided the minds of men to share each other's needs, and wants, and to provide for the common riches to which we all are air and light, and dividing these among ourselves to fulfill Thy law of bearing the burdens, each of the other. To that end, we pray Thee to give us the wisdom commensurate with these difficult and exacting times, as we seek to work together for the more mutual good of all, through sharing together these varied riches and needs which are part of our existence in the world.

We pray for the President of the United States and all others in seats of government, and especially for our nation in this time of her crisis, internal and external, that our part may be that of good citizens, loyal, judging all things, holding fast what is good. In Thy Name we pray. Amen.

**PRESIDENT BENTLEY:** If the Sergeants-at-Arms will invite the people in from outside now, I think the Civil Disorders session has adjourned. John, will you invite the remainder of them to come in and if they aren't coming in, tell them to be quiet out there.

We have been stimulated already here at this convention, in my opinion, by this wonderful Oregon weather and Oregon scenery and climate, and we are complimented this morning at this session by the presence of the distinguished chief executive of this state, and to introduce him this morning we call on the distinguished Insurance Commissioner of the State of Oregon to do the duty and, in calling on him, we can't resist the opportunity to compliment this Governor and congratulate him on what must be his most excellent appointment of one of his great claims attorneys, the appointment of Jim Faulstich as Insurance Commissioner of this state, because Jim Faulstich has done a superb job, one that is very typical of the new trend in this Association of vigorous, bright, intelligent young leaders in these offices of insurance supervision, typical of the intelligence and the new thinking in this Association, and we are happy to be associated with him and to have him introduce our distinguished guest this morning. Jim Faulstich. (Applause)

**COMMISSIONER FAULSTICH:** Thank you very much, President Bentley, for those kind remarks. I didn't know if it was I being introduced or someone else by the time you were halfway through.

It is my real pleasure to have you all here at the convention in our great City of Portland and the great State of Oregon, and to have the opportunity to introduce to you our great Governor of this state.

Oregon is fortunate to have a Governor well-grounded in the art of communication. Each of us in this room knows the principal hazard of public service — effective communication with one's administrative subordinates, with principals in the industry which we regulate, with the often over-heated and under-informed public, with the media of radio, TV, and the press.

Tom McCall was elected Governor of Oregon in November, 1966, by the largest vote ever cast for an Oregon Governor, after service as our Secretary of State beginning in 1964.

Before that time, before service as Secretary of State, he had never held public elective office, having spent most of his adult life as a correspondent, during World War II, and television newsman and commentator. Governor McCall was Administrative Assistant to the late Douglas McKay, Governor of Oregon from 1949 to 1952.

Tom McCall began his term of office by seeing the passage into law of the first major revision of Oregon's Insurance Code since 1917, House Bill 1320, a 225-page document which brought state regulation of insurance in this state into the 20th century.

You all will hear more from our vigorous Governor before his career as a public servant is over. With a great sense of personal and civic pride, I present to you the Governor of the State of Oregon, the Hon. Tom McCall. (Applause as all stand)

GOVERNOR McCALL: Commissioner Faulstich, I deeply appreciate that wonderfully warm introduction. President Bentley, other Commissioners at the head table, Dr. Wright and ladies and gentlemen of the convention, it goes without saying that as the Governor of the host state to the National Association of Insurance Commissioners, I am delighted to extend to you, each one of you, the most cordial welcome to our Beaver State. I am glad you have come, naturally, and I hope that many of you will have an opportunity to linger in Oregon after the business of this conference is completed.

Again it goes without saying that we're the state which has the most and the tallest trees, the handsomest scenery, the best hunting and fishing and some of the finest schools. And as I move around the nation more and more, I've also found that of even greater interest, especially among the knowledgeable of the United States, is the primary that we have every four years, our Presidential preferential primary, and the knowledgeable everywhere I have traveled attach unusual significance to it, feeling, and rightfully, that we are an extraordinary group of individuals, in that we are independent and well informed in our voting. Well, so much for the cliff-hanger that we had on May 28th, our Presidential preferential primary.

We also had another event in May that I think I must note for intra-family relations. My Mother, who is going to be 80 on the 11th of August, has published her first book. It's known as *Life Under the Rim Rock* and it's about her life in the cattle country. She's such a pungent observer on life and has been for the last 50 years that I was afraid we were going to have to take out some libel insurance before the book appeared, but she kept it to herself and, by golly! she has stepped on a few toes but I don't think anything in it is actionable, so there won't be any business there. (Laughter) But to tell you how remarkable she is, let me give you this one statistic. She has five children. All of them were conceived on a ranch in Oregon and all five of them were born in Massachusetts. (Laughter) That's what we call transcontinental pioneering in reverse. (Laughter)

But, of course, this is neither the time nor the place for a Chamber of Commerce talk, ladies and gentlemen, about the glories of our state, but just let me allude to that subject as one sure-fire prediction. The longer you stay in Oregon, the harder you will find it to dismiss its beauties and its hospitality from your minds; so I sincerely trust that you never succeed in doing so. I hope that you stay bewitched, one and all, and that you will return again to our state of excitement, not once but again and again.

Greater travel, obviously, between the states means warmer friendship between the people of the states and a fuller understanding of each others' aims and problems. And this increasing friendship and understanding not only result in a stronger, better-knit region, but a more united country as well. And heaven knows if there is anything America needs today, it is more unity.

It was my rather somber duty just a week ago to send to training camp an Oregon platoon of new recruits to the Marines, 17, 18 and 19 years old, and, of course, we

kept repeating, and the officer who swore them in kept repeating that their motto was *Semper Fidelis, Always Faithful*. And, of course, I think those of you who share my views on the situation we are in today don't have to worry about the young men we send over there being always faithful to the cause of freedom and the cause of America. It's the people who are back home who ought to take the oath, *Always Faithful*, to those whom we introduce into such bloody combat as we have in Viet Nam. (Applause) Thank you, and I just would add parenthetically that I think the best insurance that we could have in this situation, especially against going down on our knees through disappointment, through disenchantment and pure war fatigue, and the negotiations in Paris, is that we pledge today to be more unified and pledge today to have as insurance the old iron in our backbone which has made this country great and kept it strong.

I think it's highly appropriate, professionally speaking, gentlemen, that you have come to Oregon. We recognize the important contributions that the insurance industry makes to our economy and which insurance men have traditionally made to public life in America, and particularly at the community level, where Dr. Wright well said they have contributed to the united good neighbors, they have contributed to every civic function, and I think without the insurance industry the level of voluntarism in the United States would be about 50% of what it is today. And, of course, when I am commending people, we are so proud of our bright and efficient and energetic and hard-working Insurance Commissioner, Jim Faulstich. As far as I'm concerned, he is second to none. (Applause)

I've been reading the papers that have covered the events preceding the opening of this convention. I've seen your President Bentley on television, and I want to tell you that as Chairman of the Oregon State Traffic Commission, I share your sincere trepidation over the rising number of accidents, and I share your insistence that every state must have a comprehensive driver re-examination program. That was the No. 1 priority in my program presented to the legislature in 1967. It was defeated at the 11th hour in those closing rushes, you know, where there is so much confusion, but I want to promise you, Jim, and those interested in this industry in that legislation, I'll be fighting for it next January, fighting for this particular type of legislation. When we realize that a pilot flies Mr. Bentley out here has two physical examinations per year, and yet I have never been re-examined at 55 years of age since I first got my driver's license. Fighting for this legislation, fighting to add 100 more state policemen to our staff, and then fighting also for a bill that will say that no young person under 18 should have a driver's license unless he or she has engaged fully in the official driver training courses that are available.

Also, as Chairman of the Crime Coordinating Council of the State of Oregon, I share your concern with the rising rates of crime, and I also note with particular interest the deficits you have in the case of disasters such as riots and in the case of natural disasters, this effort at reinsurance. When I was running for Congress in 1954, I was told by the medical profession I could not endorse the Eisenhower plan for reinsurance for medical care. Now, if that had been passed in 1954, the medical care picture would be a far different one from what it is today. But I think we've also got to say that any plan of reinsurance must keep the private sector of the economy of the United States uppermost in any situation it chooses to follow.

I also share your views on gun control legislation, many of you. We checked with our superintendent of state police. That gun that it took seconds to run down the Kennedy assassin weapon in Los Angeles, he said it would have taken hours and maybe days and they might never have been able to run it down the way we do things in Oregon. I promise you at the same time that this legislation will be reasonable and it will not deprive any responsible citizen of the use of his rifle or his revolver.

And then, as Jim mentioned, recognizing the vital importance of the insurance industry, the Oregon Legislature did last year revise Oregon's archaic insurance code for the first time in half a century. And there, ladies and gentlemen, is the man who directed the work, a monumental effort, to bring us into the last third of the 20th century, the prime author, the prime architect, again Jim Faulstich. (Applause)

Well, without praising my administration, but I want to know and have you know that in Oregon, as nationally, we realize the insurance industry is skyrocketing. In life insurance alone, while our population increases about 2 per cent a year, life insurance in force grows 10 per cent a year.

Insurance has had a tremendously telling impact on the economy of our state. Over the past ten years, the total premium volume has doubled in Oregon, the same thing as has happened in the nation as a whole. Life and health insurance have done much to reduce the burden of the state in supporting the family upon the death or the injury of the breadwinner. And the savings to the taxpayers, if they only knew it, in this one area amounts to hundreds and hundreds of millions of dollars per year.

And I am aware of your constant re-evaluation in this area of life and health insurance. You are always looking for a better break for the consumer. Ahead for Oregon, ahead for the nation, all of us in this room can safely forecast an explosive increase in population, and while this increase may mean prosperity and progress for the United States, it also presents a tremendous challenge to the insurance industry, and to those of you who are charged with the supervision of that industry.

In the last third of the 20th century the industry will be challenged as never before to maintain the present service without losing any of their demonstrated ability.

There are some who say you can't do it. There are many who maunder and worry. They say the burden is too great, that you can't handle it. But I simply want to say to you this morning as I welcome you with all the cordiality I possess to our great State of Oregon, that I am confident with the guidance of the Commissioners, with the officials in the private industry I know who serve so well and with such distinction, the insurance industry will rise to this tremendous occasion. And it is my earnest hope that just such conclaves as this great convention will give all of you the collective insight into the ways that you and I and all of America must follow to a better and a brighter tomorrow. Good luck, gentlemen. (Applause as all stand)

**PRESIDENT BENTLEY:** Thank you so much, Governor McCall. It should be obvious to all of us that your exemplary leadership here in your state has already lent great quality to the business of insurance and certainly to the responsible task of regulating this great business.

Consistent with NAIC positions, the Vice President of NAIC is called upon to respond to our Gubernatorial welcome, and this morning we will call upon our mustachioed Vice President, Charley Howell of New Jersey, to respond here. (Applause)

**COMMISSIONER HOWELL:** Mr. President and my distinguished colleague here, Jim Faulstich, and particularly Governor McCall, as I explained out in Hawaii about six months ago, the two main duties of the Vice President of this organization are to respond to the address of welcome of the Governor and the public officials and to go around and praise my leader, Jim Bentley, in the hope that I'll have his support in the election that comes up next Thursday. (Laughter)

But, Governor, we are deeply appreciative of your being with us this morning, and it's very refreshing to find a chief executive of a fine state who exhibits a real understanding of some of the problems that we are attempting to come up with answers to. They are tough problems and the answers are not always easy to find. But we do appreciate that you have done your homework and have come to us with a very stimulating message here this morning.

I want to tell you and all of your partners in government in Oregon and Portland that this has been a convention, the welcome, our working conditions and everything here have been just as great and fine as they possibly could have been. There were rumors around that we might run into various sorts of weather, different from what we have encountered since we have been here, but everything has been just great, the climate, the reception, and your wonderful greetings here this morning. We are so happy that you were able to come and we deeply appreciate it and I know that this is going down in history as one of the most successful meetings of this Association. Thank you very much, sir. (Applause)

**PRESIDENT BENTLEY:** Governor McCall has a long trip to another part of the State of Oregon and he has asked us to excuse him this morning. Governor, we are glad to have had you here. (Applause)

The ranks of this Association since our Honolulu meeting and since the June meeting of last year have been again strengthened with the appointment of new Commissioners, more than half of them new faces here at this convention. Although he assumed office in early 1967, it has not been possible for him to attend the two intervening sessions of the NAIC and we have with us today Director W. W. Fritz, the



Director of Insurance of the State of Alaska. Director Fritz. (Applause)  
I am happy to report that he has been able to revitalize the operation and increase the budget of his Department.

The new Director of Insurance of the State of Arizona, Hon. Jerry P. Shea. (Applause)

And for the State of Arkansas, a new Insurance Commissioner, Hon. Allan W. Horne. (Applause)

And from the State of Hawaii, a new Insurance Commissioner, the Hon. Edwin H. Honda. (Applause)

And a vigorous new leader from the State of Kentucky is the Commissioner of Insurance there, the Hon. Robert D. Preston. (Applause)

A new Director of Insurance for the State of Ohio, the Hon. Eugene P. Brown. (Applause)

Although this is not his first meeting, it is our first opportunity to present him to the Convention, the new Commissioner of Insurance for the Commonwealth of Puerto Rico, the Hon. Julio R. Hernandez. (Applause)

He was unable to attend our last meeting and consequently this is again our first opportunity to introduce the recently appointed Insurance Commissioner of the State of Rhode Island, the Hon. Ralph A. Petrarca. (Applause)

And this is his first convention with us, succeeding the distinguished William Hunter McLean, the Hon. George M. Cowden, Chairman of the State Board of Insurance of the State of Texas. (Applause)

Now, we do have some additional guests here this morning. We have several representatives from Canada, several of our Canadian Superintendents of Insurance who come each year from Canada. I saw Roger Camaraire here earlier. Roger is the President of the Canadian Superintendents' Association this year. (Applause) And I think I saw L. D. D'Arcy out in the corridor, Superintendent of Insurance of New Brunswick. (Applause)

Are there other superintendents here from the provinces of Canada? Apparently not.

I am not sure that he was introduced at the last session, the new Commissioner of Insurance from the State of Maine, Mr. Frank Hogerty. (Applause)

We also have our distinguished and annual guest here with us this morning, the distinguished Supervisor of Insurance from the Republic of Mexico, the Hon. Pedro Reyner, Pedro. (Applause)

Pedro has as his guest here this morning a man who we will call on at the announcement period, and Pedro will introduce his guest from Mexico for a few remarks.

Now is the time for the roll call of the membership of this Association and this is always a job for our colorful Superintendent of Insurance of the State of New Mexico, Ralph Apodaca.

**SUPERINTENDENT APODACA:** In order to conserve time, it is suggested during the roll call that when the state is called, the official give his name, and if he has staff members, he leave a list with the Secretary in order to make a complete record of this meeting.

Alabama—Walter S. Houseal, Superintendent.

Alaska—W. W. Fritz, Director.

Arizona—Jerry P. Shea, Director.

California—Richard S. L. Roddis, Insurance Commissioner.

Arkansas—Allan W. Horne, Commissioner.

Colorado—J. Richard Barnes, Commissioner.

Connecticut—

Delaware—Robert A. Short, Commissioner.

District of Columbia—

Florida—Broward Williams, Commissioner; E. A. Faircloth, Executive Assistant; E. J. Gallagher, Rate Analyst; Sam Rogers, Chief, Rating Division; Thomas A. Waddell, Attorney at Law; Chief, Rehabilitation Division; George D. McDonald, Life Deputy; Bruce Caswell, Regional Director.

Georgia—James L. Bentley, Commissioner.

Guam—

Hawaii—Edwin H. Honda, Commissioner.

Idaho—John R. Blaine, Commissioner.

Illinois—John F. Bolton, Jr., Director.

Indiana—Joseph G. Wood, Commissioner.

Iowa—Lorne R. Worthington, Commissioner.

Kansas—Frank Sullivan, Commissioner.

Kentucky—Robert D. Preston, Commissioner.

Louisiana—Dudley A. Guglielmo, Commissioner.

Maine—Frank M. Hogerty, Jr., Commissioner.

Maryland—Newton I. Steers, Jr., Commissioner.

Massachusetts—C. Eugene Farnam, Commissioner.

Michigan—David J. Dykhouse, Commissioner.

Minnesota—Thomas C. Hunt, Commissioner.

Mississippi—Walter D. Davis, Commissioner.

Missouri—Robert D. Scharz, Superintendent.

Montana—Elmer V. Omholt, Commissioner.

Nebraska—Benjamin C. Neff, Jr., Director.

Nevada—Louis T. Mastos, Commissioner.

New Hampshire—Donald Knowlton, Commissioner.

New Jersey—Charles R. Howell, Commissioner; Horace J. Bryant, Jr., Deputy;  
W. Harold Bittel, Chief Actuary; William F. Faherty, Assistant to Commissioner.

New Mexico—Ralph F. Apodaca, Superintendent.

New York—Richard E. Stewart, Superintendent.

North Carolina—Edwin S. Lanier, Commissioner.

North Dakota—K. O. Nygaard, Commissioner.

Ohio—Eugene P. Brown, Director.

Oklahoma—JOE B. HUNT: They say the next Commissioner of Oklahoma will have to have gray hair and hemorrhoids; the gray hair to give him a look of distinction, the hemorrhoids to give him a look of concern. Until that happens, Joe B. Hunt is the Commissar of that state. (Laughter)

(Also present from Oklahoma—F. Anthony Zahn, Assistant General Counsel; John A. Freeman, Director of Agents' Licensing.)

COMMISSIONER APODACA: Commissioner, you always spoil the dignity of this group. There are no people in here who are going to vote for you. (Laughter)

COMMISSIONER HUNT: I apologize.

Oregon—James R. Faulstich, Commissioner.

Pennsylvania—David O. Maxwell, Commissioner.

Puerto Rico—Julio R. Hernandez, Commissioner.

Rhode Island—Ralph A. Petrarca, Commissioner.

South Carolina—Representative present.

South Dakota—Warren E. Dirks, Commissioner.

Tennessee—David M. Pack, Commissioner.

Texas—Ned Price, State Board of Insurance; Durwood Manford, State Board of Insurance; George M. Cowden, State Board of Insurance.

Utah—C. N. Ottosen, Commissioner.

Vermont—James H. Hunt, Commissioner.

Virgin Islands—

Virginia—T. Nelson Parker, Commissioner.

Washington—Lee I. Kueckelhan, Commissioner.

West Virginia—Frank R. Montgomery, Commissioner.

Wisconsin—Robert D. Haase, Commissioner.

Wyoming—William G. Walton, Superintendent.

From the Provinces of Canada: Roger A. Camaraine, Superintendent, Province of Quebec; L. D. D'Arcy, Deputy Province Secretary, Province of New Brunswick.

Mexico—Pedro Reyner, Commissioner.

Mr. Chairman, we have a quorum present.

PRESIDENT BENTLEY: Thank you, Ralph.

The Chair now yields the gavel to our Vice President, Commissioner Howell, for the purpose of the annual report of the President, and the

time having arrived for his report, one is somewhat at a loss to find a point of beginning. Of course, the first impression of all of us is one of very profound gratitude to Oregon, Commissioner James Faulstich and his colleagues, for the obvious success of this meeting, and to General Chairman Pete Brooks and his associates, to Governor Tom McCall of his exciting and colorful state, and they deserve our enthusiastic applause for their traditional hospitality which has been so generously lavished upon us all already here at this convention. I think that the lavish planning and the great preliminary effort of these men and the smooth efficiency of the convention experienced already matches only the great work load that we have ahead for this week.

Gentlemen:

The time having arrived for our semi-annual report of the President on another year of activity, one finds it somewhat difficult to select a point at which to begin.

The first impression of all of us is, of course, one of gratitude to Oregon Commissioner James R. Faulstich and his colleagues for the obvious success of this convention. General Chairman Pete Brooks and his associates, Mayor Terry Schruck of this exciting city and Governor Tom McCall from the great State of Oregon deserve our enthusiastic applause for their traditional hospitality lavished in such an exceedingly gracious manner upon us. The planning and preliminary efforts of these men and the smooth efficiency of this convention match the challenging workload ahead for all of us this week.

This convention marks the high point for both the industry and its regulation in a complicated year of activity. Both external and internal affairs of this association during the current year probably have been unmatched in a score of years for dramatic and far-reaching impact. While few of these events have reached a point of culmination, the expertise and understanding of our leadership has made it possible to shape the direction of much of the external activity. I believe that it has been a year of almost unequalled production in planning for impact by NAIC and its leadership.

Events taking shape five years ago and more in the business of insurance and the functioning of this organization have moved near the point of climax during the year.

Current concern at the national level with the business of automobile insurance has its roots in events which foretold a change in the American society over 25 years ago.

The dramatic concern of White House study committees, NAIC Select Committees and insurance industry inquiries with the present impact of civil disorders on the business of insurance compounded and climaxed concern expressed by this Association five and six years ago with a constricting market in congested areas and residual dwellings generally.

Fundamental shifts in the administrative staff structure of this organization receiving final approval and implementation at this meeting had their beginnings as early as 20 years ago when a Central Office was created, but its ultimate success inhibited by compromises and reluctance to accept the need for comprehensive staff planning and non-policy making research functions.

The year has marked a new plateau of events having their origins many years earlier. Assignments which might normally have been spotlighted at an annual meeting have received hardly adequate notice at this meeting, while answers during the year and during the week have been sought for these more dramatic and more pressing needs.

The drama of the present needs was predicted last October at the American Life Convention in Dallas when Federal Trade Commission Chairman, Rand Dixon, predicted that the entire insurance industry would face "a new stardom" in the months ahead. A Presidential Commission on Civil Disorders including an Insurance Advisory Panel had already held its first series of hearings. Exhaustive inquiries into the subject of automobile insurance had already been called for by members of the U. S. Congress.

Insurance fully attained the rank of stardom when it received attention in the State of the Union message of the President of the United States last January.

Therefore, an industry, which has grown efficiently and served the American public well for over 200 years of growth and more than 100 years of regulated activity, now finds itself the principal target in a binge of consumerism. Undoubtedly, insurance inquiries will dramatically expand the consumerism issue in the months ahead and will certainly project insurance as the most investigated business in America.

A restless public in recent years, failing or refusing to understand either the insurance contract or the fundamental "share the risk" concept of insurance and frequently inspired by labor demands, has stimulated much of this political inquiry into the business. We can be grateful that this unrest and these inquiries with threats and implications for additional inquiries have already inspired self-examination and self restraint by the industry which hopefully will continue its volunteer efforts to correct troublesome areas while sufficient time remains for volunteer initiative.

States have individually and collectively accepted the responsibility of broadening our scope of activity and generally recommitting ourselves to programs of revitalization State by State and particularly as a national organization.

We fully accept criticism where criticism is due, and we should accept the consequences when constructive criticism is not met with well-defined solutions. Our capabilities and our determination to meet criticism and respond effectively is a matter of rather impressive record.

The record should also clearly read that blame for much of today's national travail including insurance headaches must rest upon the shoulders of a Congress and a national leadership which has not squarely faced up to such issues as inflation, the current financial crisis and civil disorders. Surely no member of the Congress of the United States can today justify pointing a finger at the States or challenging the sincerity or the efficiency of our functions.

Insurance is almost incidental to a whole national attitude of transition and change. The cost of insurance — an aspect of consumer concern — is caught in a spiral of inflationary circumstances which Congress itself has allowed to develop since the end of World War II.

Hardly more than \$.30 worth of raw cotton was used in the processing of the shirt which I wear at a cost of something like \$7.00. Hardly more than \$100 worth of raw iron ore was necessary for a \$4,000 automobile which I drive. The difference between the raw material and the finished product is primarily the cost of labor. But even the price of labor today is not the full answer to inflationary spirals nor, of course, the full reason for troublesome areas in automobile insurance. Insurance for the automobile is a small part of the great drama created by the revolution of the automobile itself in this country. Involved is the cost of steel, the cost of rubber, petroleum, doctor bills, law enforcement, the court system, traffic safety, driver education, labor strikes, uncontrolled inflation, this new national issue of consumerism, and a hundred other factors as well as free enterprise itself where a stigma is attached by some to the profit motive which has stimulated the American businessman in this industrial revolution.

Likewise adequate commercial and residential coverage in congested areas of American cities is influenced by circumstances over which neither regulators of insurance nor executives of insurance have control or can exercise influence.

The response of government to the automobile insurance concern must match and exceed that of inquiries into the impact of riots upon the business of insurance. Inquiries now beginning in Washington must be total, unbiased, unemotional, and non-political. A superficial and general inquiry or an in-depth review of a few incidental areas will be inadequate and would be a disservice to the American people.

We will benefit by a review which is completely comprehensive and objective. We will suffer in the absence of a study of the total picture.

No NAIC committee has applied itself more diligently than the select group of insurance counselors headed by Commissioner Nelson Parker of Virginia to give direction to NAIC thinking and counsel the insurance advisory panel headed by Governor Richard Hughes of New Jersey.

While legislation to create the Federal Insurance Development Corporation has passed the major hurdles, the basic proposal of this Association to authorize deferral of taxes on the accumulation of company reserves for all catastrophes is yet to be considered by Congress. The concept has received prestigious endorsement and will undoubtedly receive influential Congressional support.

This Association has recognized the need for an immediate response by the Federal Congress to emergencies created by civil commotions, a resulting state of sustained panic by reinsurers and a constricting reinsurance market. The industry should also now recognize the practicality of the tax deferral concept and the long range need for an accumulation of reserves — a self-reinsurance program — to meet demands for additional capacity and the future stability of the industry itself.

Reports are yet to be made at this meeting on the response of the industry to the Hughes' Panel recommendations for FAIR Plans. It is suggested that volunteer action will be sufficient. Total and complete cooperation and participation in these plans if voluntary will be necessary. Participation short of this total approach can only result in mandatory plans in other States similar to examples already set in some jurisdictions.

While the great focus of events has been upon these external dramatics, equally fundamental shifts have begun and should reach a new focus at this meeting in the internal life of this organization.

Our quite temporary mechanics for financing have substantially more than doubled our annual income. Quality personnel has been retained; new procedures have been invoked.

The former Superintendent of Insurance for the State of New York and the original author of a rejuvenated research program for this Association, the Honorable Robert Dineen, has been retained and will assume full duties next month. He will be assisted by one of the foremost young research technicians in America, Mr. Jon Hanson, who has already demonstrated his knowledge and expertise. Counsel has been employed in Washington. Mr. Peyton Ford, Former Deputy Assistant U. S. Attorney General, has already rendered services to this Association which undoubtedly would have been unattended without his employment.

A preview of a new NAIC procedure has been submitted directly to you. The brief session directed by Messrs. Dineen and Hanson at the Zone 5 Meeting and subsequently circulated to all departments in abbreviated form is a refreshing preview of briefing sessions which we may anticipate in the future.

We held a staff meeting of NAIC officers and administrative personnel earlier this month in Chicago. The potential for a coordinated effort in diversified activity by NAIC staff personnel was immediate and to me thoroughly stimulating. Research assignments are now possible for a research technician but the potential and assistance in research by the Valuation of Securities Office have been identified and put to use. There is also the great potential to be considered in the months ahead of combining examination of insurance company activities at the Central Office with compatible functions of the Valuation Office. This new thrust of NAIC encompassing finances, personnel, procedures and the coordinated effort of all staff personnel is embarrassingly overdue but it is now a reality and every Supervisor in the nation will ultimately benefit.

The brief tenure of one year as President of this Association affords one hardly more than an opportunity to broaden his own horizon and identify the great accomplishments as well as potentials of his colleagues and NAIC. Ones' observations are numerous and should be constructive.

The monolithic size of the American Insurance Industry and its ever expanding potentials is a great challenge to the efficiency and fulfillment of our State responsibility. No Supervisor no longer can concern himself excessively with events in his State and the impact of his policies upon his State alone. Our actions and attitudes in this computerized age go beyond the borders of our respective States. The need for strengthening our capabilities and coordination is a screaming imperative. We should anticipate an acceleration in this need for consistent attitudes by all departments. Identified needs such as greater uniformity in the approval of policy forms, greater consistency in the admission of companies, and expeditious responses to industry needs must be understood, accepted and met. Priority must be given to implement the authority of States and standardize the attitude of all jurisdictions rather than supplant or yield up their authority.

The proliferation and conglomerates by way of the holding company technique emphasizes the need for reviewing standards and allowing flexibility. New attitudes in several States and noticeable trends in others which allow more flexibility in rate-making coupled with tougher authority to police abuses are successful examples of delegating broader responsibility to a regulated industry.

The almost casual creation at our Honolulu Session of a committee for liaison with State agencies holds great promise for the future support of this Association. The Subcommittee, headed by Commissioner Maxwell of Pennsylvania, has already stimulated lively communication with Attorneys General. A greater potential of this

Subcommittee rests in the opportunity of liaison with Governors of several States themselves. It is unreasonable for the Governors of this nation to depend upon Insurance Commissioners exclusively to bear the burden of justifying, promoting and almost exclusively supporting this concept of State responsibility. Here is the last bastion of primary State authority. Here is a monolithic tax income approaching one billion dollars per year to the States from the industry which alone should cause every Governor in every State to involve himself in our efforts to strengthen our individual departments with finances, personnel and the new research techniques.

I urge you in the months ahead to seek new avenues of communication by way of the National Governors Conference and the Council of State Governments with the Governors of the States themselves.

I thank you, my dear friends, for the happy experiences and the delightful opportunities which my service this year as your President has made possible for me. The satisfaction of contributing a part of my life to this Association, this magnificent business and the public good has matured and influenced my life and left my family and me profoundly grateful to all of you — one by one — for your understanding and your great support.

Good luck to you!

God Bless You!

(Applause as all stand)

Thank you very much.

**PRESIDENT BENTLEY:** The next item on the agenda is the creation of the Resolutions Committee, and the Chair Designates Commissioner Bob Haase of Wisconsin Chairman of the Committee on Resolutions, and to serve with him, five additional Commissioners, the Hon. W. W. Fritz of Alaska, Hon. Bob Walton of Wyoming, Hon. Jerry Shea of Arizona, Hon. Frank Hogerty of Maine, and Hon. Elmer Omholt of Montana.

Under the subject of announcements, I think it is appropriate that we state here something that always develops in the NAIC convention. It is our intention to adjourn this convention, not on Friday at noon, as the agenda indicates here, but it is our intention to adjourn this convention, hopefully, no later than 1:00 o'clock Thursday afternoon. Therefore, the next Plenary session of NAIC will follow immediately the meeting of the Executive Committee on Thursday morning, and the Executive Plenary session will immediately follow that session.

It should not be necessary to remind each Commissioner also who plans to leave this NAIC meeting prior to that session on Thursday morning that his successor or his representative here, in order to participate in the election Thursday morning, must have a written letter of authority from his Insurance Commissioner, a written letter of authority to participate, not necessary a written letter of instructions on how to vote.

We had a request earlier this morning from our great colleague, Pedro Reyner, that he be allowed a moment or so on the program this morning to introduce to all of us a visitor to this convention from the Republic of Mexico, a member of the Cabinet from Mexico. Pedro, would you like to introduce your visitor here this morning.

COMMISSIONER REYNER: Gentlemen, it is a real pleasure for me to introduce for the first time at any NAIC convention, a member of the Mexican Cabinet, the Undersecretary of Tourism of the Republic of Mexico, Dr. Legaspi. (Applause as all stand)

DR. LEGASPI: Mr. Chairman, distinguished ladies and gentlemen, members of this convention:

A constantly improved image of Mexico has become the highest reward to the Mexican-speaking people. The development of our country has reached a stage of political stability in a world full of uncertainty. The economy of the country has steadily grown. In the last 20 years we have witnessed this especially happen. One very important aspect of this has been tourism. Last year, 1,700,000 foreign tourists visited Mexico, 87% of them from the United States. This has sparked a 12% labor growth between the years of 1966 and 1967.

The Department of Tourism of the Mexican Government has made every effort to furnish a hospitable and receptive land in order that the visitor may continue to enjoy the modern-day Mexico and the vestiges of our illustrious past. Mexico can offer fine facilities to explore its land, good climate, topographic beauty, modern conveniences. While endeavoring to improve the attractiveness of our country, we at the same time are trying to eliminate any possible obstacles that may hinder the tourism. One of the changes that we are working on is to substitute the present-day tourist card, good for only one entry, with a new card good for five years and multiple entries. \* \* \* Fifteen new luxury hotels are under construction in Mexico City alone, which will make 5,500 more rooms available. The urban conditions are being constantly improved as a requirement of modern-day living. This is a brief outline to give you an idea of the Mexico which has become the favorite vacation land of the world. It has become so because of the efforts of all the Mexicans, united for spiritual and material values. We wish the betterment of the country and we invite all of you to come to Mexico to share the warmth and hospitality of our countrymen. Thank you very much. (Applause as all stand)

PRESIDENT BENTLEY: Thank you, Dr. Legaspi.

Again, I would remind all Commissioners, and particularly all committee chairmen, to expedite the work of their committees and have their reports ready early Thursday morning so that we can move along with our Executive Committee meeting and our Plenary session.

Are there any other announcements? If there are no other announcements and there is no other business to be transacted, the First Plenary Session is adjourned. See you on the Mountain.

... Recessed ...



1968 ANNUAL MEETING — JUNE 16-21, 1968

PORTLAND HILTON HOTEL

PORTLAND, OREGON

ORDER OF BUSINESS

SECOND PLENARY SESSION - MTG. 49 THURSDAY - 2:00 P.M.  
 JUNE 20, 1968  
 BALLROOM A

PRESIDING

HON. JAMES L. BENTLEY, PRESIDENT - GEORGIA

1. CALL TO ORDER 1968 ANNUAL MEETING OF THE  
 NATIONAL ASSOCIATION OF  
 INSURANCE COMMISSIONERS

2. ROLL CALL (Only if quorum is HON. RALPH F. APODACA  
 DOUBTED) SUPERINTENDENT OF INSURANCE  
 STATE OF NEW MEXICO  
 SECRETARY-TREASURER OF NAIC

3. COMMISSIONERS' AUTHORIZED REPRESENTATIVES

NOTE: You may wish to announce that LETTERS of AUTHORITY, in accordance with ARTICLE 4 of the NAIC CONSTITUTION, are necessary before REPRESENTATIVES of MEMBERS are permitted to vote.

4. REPORTS OF COMMITTEES (See following list of Committees pp. 368-370)

NOTE 1: Probably the most important purpose of this meeting is to provide an opportunity for ALL THOSE INTERESTED to express their views regarding the REPORTS submitted. Most, or all of the COMMITTEE REPORTS which will be submitted, have been distributed so that EVERYONE could review them and be prepared for discussion.

NOTE 2: ALTERNATIVE PROCEDURE

(A) If a COMMITTEE REPORT draws discussion and is considered CONTROVERSIAL, the COMMITTEE CHAIRMAN, or his authorized representative, should make a motion to RECEIVE THE REPORT

BUT

(B) If a COMMITTEE REPORT draws no discussion, the COMMITTEE CHAIRMAN, or his authorized representative, may make a motion to ADOPT the REPORT. This procedure will conserve time at the PLENARY EXECUTIVE SESSION - 3, as only the controversial REPORTS will be presented for FINAL ACTION.

NMS - No Meeting Scheduled

REPORTS OF COMMITTEES

DATE & ACTION

EXECUTIVE (A) COMMITTEE (MTG. 48)

HON. NED PRICE, CHM., TEXAS

HON. RICHARD S. L. RODDIS, V.CHM., CALIF.

Includes reports (if any) by:

- Future Sites for NAIC Meetings (A1) Subcom. (Mtg. 17)
- Uninsured and Partially Uninsured Non-Regulated Plans (A2) Subcom. (Mtg. 21)
- Reorganization and Public Information Matters (A3) Subcom. (Mtg. 13)
- Liaison with State Agencies (A4) Subcom. (Mtg. 3)
- BLANKS (A5) COMMITTEE (MTG.+39)
  - Fire, Casualty and Reciprocal Blank (A5a) Subcom. (Mtg.+40)
- MEXICO INSURANCE PROBLEMS (A6) COMMITTEE (MTG. 29)
- CIVIL DISORDERS - INSURANCE PROBLEMS (A7) COMMITTEE (MTG. 30)

EXAMINATIONS (B) COMMITTEE (MTG. 36)

HON. LEE I. KUECKELHAN, CHM., WASH.

HON. C. EUGENE FARNAM, V.CHM., MASS.

Includes reports (if any) by:

- Examinations Manual Revision (B1) Subcom. (Mtg. 14)
- Examinations of Accts. & Records by Electronic Computers (B2) Subcom. (Mtg. 25)
- Compensation System of Examinations (B3) Subcom. (NMS)
- Examinations Procedure for Rating & Stat. Organizations (B4) Subcom. (Mtg. 9)

FEDERAL LIAISON (C) COMMITTEE (MTG. 31)

HON. RICHARD E. STEWART, CHM., N. Y.

HON. GEORGE M. COWDEN, V.CHM., TEXAS

LAWS AND LEGISLATION (D) COMMITTEE (MTG. 34)

HON. RICHARD S. L. RODDIS, CHM., CALIF.

HON. C. EUGENE FARNAM, V.CHM., MASS.

Includes reports (if any) by:

- Legislation to Modify Schedule "P" Statutes (D1) Subcom. (Mtg.+4)
- Legislation Relating to Holding Companies (D2) Subcom. (Mtg. 26)
- Legislation to Regulate Long Term Credit Insurance (D3) Subcom. (Mtg. 18)
- Legislation Dealing with Unauthorized Insurers (D4) Subcom. (Mtg. 15)
- Reorganization, Receivership & Liquidation Procedures (D5) Subcom. (Mtg. 16)
- Proxy & Insider Trading Regulations - Administration Experience (D6) Subcom. (Mtg. 22)

LIFE, ACCIDENT AND HEALTH INSURANCE (E) COMMITTEE (MTG. 41)

HON. BROWARD WILLIAMS, CHM., FLA.

HON. T. NELSON PARKER, V.CHM., VA.

Includes reports (if any) by:

- Accident and Health Insurance (E1) Subcom. (Mtg. 5)
- Credit Life and Credit Accident & Health Insurance (E2) Subcom. (Mtg. 28)  
Mortality & Morbidity Experience - Credit Life & Credit A&H (E2a)  
Subcom. (Mtg. 1)
- Fraternal Insurance (E3) Subcom. (NMS)
- Life Insurance (E4) Subcom. (Mtg. 10)
- Non-Profit Hospital & Medical Service Associations (E5) Subcom. (Mtg. 6)
- Variable Annuities (E6) Subcom. (Mtg. 23)

PROPERTY, CASUALTY AND SURETY INSURANCE (F) COMMITTEE  
(MTG.+37)

HON. DONALD KNOWLTON, CHM., N. H.

HON. BROWARD WILLIAMS, V.CHM., FLA.

Includes reports (if any) by:

- Rates and Rating Organizations (F1) Subcom. (Mtg. 27)  
To Review Statistical Plans (F1a) Subcom. (Mtg. 2)
- Unauthorized Insurers (F2) Subcom. (Mtg. 24)
- Hurricane-Flood and Related Insurance (F3) Subcom. (Mtg. 11)  
Federal Government Flood Program (F3a) Subcom. (NMS)
- Joint Industry Study of Mortgage Insurance Problems (F4) Subcom.  
(Mtg. 7)
- Actuarial (F5) Subcom. (Mtg.+8)
- To Consider Premium Financing by Insurers (F6) Subcom. (Mtg. 12)
- Regulation of Special Property Coverages . . . (F7) Subcom. (Mtg.+38)
- Regulations of Financial Guarantees (F8) Subcom. (Mtg. 19)

VALUATION OF SECURITIES (G) COMMITTEE (MTG. 35)

HON. T. NELSON PARKER, CHM., VA.

HON. RICHARD E. STEWART, V.CHM., N. Y.

Includes reports (if any) by:

- Valuation of Securities (G1) Subcom. (Mtg. 20)

ADVERTISING OF INSURANCE (H) COMMITTEE (MTG. 32)

HON. FRANK R. MONTGOMERY, CHM., W. VA.

HON. ROBERT D. PRESTON, V.CHM., KY.

RESOLUTIONS (I) COMMITTEE

## 5. ANNOUNCEMENTS (if any)

## 6. ADJOURNMENT - PLENARY SESSION - 2

NOTE: Before adjourning you may wish to announce that the NEXT PLENARY SESSION (MTG. 50) is in EXECUTIVE SESSION and will convene in this ROOM (BALLROOM A) FRIDAY, JUNE 21, 1968 at 9:30 A.M. to consider:

## (A) COMMITTEE REPORTS

FINAL ACTION on those REPORTS which were RECEIVED (and NOT ADOPTED) during the session of PLENARY SESSION - 2.

## (B) ELECTIONS

Officers, Executive Committee Chairman, and three (3) Members-at-Large to serve during the next NAIC fiscal year.

## (C) ELECTION REPORTS FROM NAIC ZONES.

## (D) OTHER MATTERS which may be appropriately submitted for NAIC consideration.

END OF PLENARY SESSION - 2

## PLENARY SESSION - 2

The Second Plenary Session convened Thursday forenoon, following completion of the Executive Committee meeting, Hon. James L. Bentley, President, presiding.

**PRESIDENT BENTLEY:** Will you all please be seated. The Second Plenary session will now come to order. We have a quorum present and we will proceed. There are still some subcommittee reports to be completed but they should be available very shortly.

Is the Secretary present to call the roll? Commissioner Barnes, would you assist us in calling the roll?

**COMMISSIONER BARNES:** I move we dispense with the calling of the roll and declare a quorum present.

**PRESIDENT BENTLEY:** Is there a second to that motion?

**COMMISSIONER PRICE:** Second.

**PRESIDENT BENTLEY:** Is there objection to a quorum being declared present? The Chair hears no objection and a quorum is declared present.

We have a number of letters of authority from Commissioners to members of their Department. The Chair will receive all letters of authority from Departments that have not as yet submitted these letters of authority. We now, for your information, have letters of authority from Commissioner Wood of Indiana authorizing Mr. Walter Christie; Mr. Broward Williams authorizing Mr. Faircloth; Director Bolton of Illinois authorizing Mr. O'Brien; Mr. Preston of Kentucky authorizing Mr. Evans; Mr. Joe Hunt of Oklahoma authorizing Mr. Zahn; Mr. Robert Short of Delaware authorizing Mr. De Geeter; a telegram from Mr. Ed. Lanier of North Carolina authorizing John Daniels; from Mr. Dudley Guglielmo authorizing the Sergeant-at-Arms of this Convention, Mr. Ben Franklin; a resolution from the Board of Texas authorizing Ned Price to represent the State of Texas; from Commissioner Farnam of Massachusetts authorizing Mr. George Howarth. Are there any Commissioners left? (Laughter) Mr. Scharz of Missouri authorizing Jim Dalton; Mr. Parker of Virginia authorizing John Parker; Mr. Thomas Hunt of Minnesota authorizing Mr. Anderson; Mr. Charles Gambrell authorizing Mr. Howard Clark.

Are there other letters of authority to be received here? Apparently not.

We will now proceed with the acceptance of committee reports. It is suggested that each committee chairman digest, as his report is

submitted, whether or not there is any objection or concern or anticipated controversy with his report, in order that we might go ahead and adopt the report here at this open session, in the absence of any comment that anybody wants to make in executive session or any secret remarks anybody wants to make. And the purpose of this open session here this morning is to receive these reports and hear any remarks from industry representatives here who have response or additions or recommendations that they would like to make to this committee. So we hope you gentlemen will freely express yourselves as these reports are received.

PRESIDENT BENTLEY: The first report is that of the Executive Committee, Chairman Ned Price of Texas.

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EXECUTIVE (A) COMMITTEE

AGENDA - MTG. #48

THURSDAY A.M.

JUNE 20, 1968

9:00-11:00

BALLROOM A

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References

1968 Proc. VOL. I pp. 1-6; 47-60; 83

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EXECUTIVE (A) COMMITTEE Report

(Special Meeting 3/11/68 Jackson, Wyoming)

1. To Study Future Sites for NAIC Meetings (A1) Subcom. Report (Mtg. 17)

Hon. J. Richard Barnes, Chm., Colo.

Refs: 1966 Proc. VOL. II p. 297 (additional references)  
 1966 Proc. VOL. II pp. 302-304  
 1967 Proc. VOL. I p. 47  
 1967 Proc. VOL. II pp. 287-288  
 1968 Proc. VOL. I pp. 53-54

2. Uninsured and Partially Uninsured Non-Regulated Plans (A2) Subcom. Report (Mtg. 21)

Hon. J. Richard Barnes, Chm., Colo.

Hon. Robert D. Haase, V.Chm., Wis.

Refs: 1966 Proc. VOL. II p. 297 (additional references)  
 1966 Proc. VOL. II p. 298 NR  
 1967 Proc. VOL. I p. 40 NR  
 1967 Proc. VOL. II p. 250  
 1968 Proc. VOL. I p. 55

3. To Study Reorganization and Public Information Matters (A3) Subcom. Report (Mtg. 13)

Hon. T. Nelson Parker, Chm., Va.

Hon. Richard E. Stewart, V.Chm., N. Y.

Refs: 1966 Proc. VOL. II p. 297 (additional references)  
 1966 Proc. VOL. II pp. 304-308  
 1967 Proc. VOL. I pp. 44-45; 48-52  
 1967 Proc. VOL. II pp. 291-299  
 1968 Proc. VOL. I pp. 57-60

4. Liaison with State Agencies (A4) Subcom. Report (Mtg. 3)

Hon. David O. Maxwell, Chm., Pa.

Hon. Benjamin C. Neff, V.Chm., Nebr.

Ref: 1968 Proc. VOL. I p. 49

5. BLANKS (A5) COMMITTEE Report (Mtg. 39)  
 HON. JAMES H. HUNT, CHM., VT.  
 HON. RICHARD S. L. RODDIS, V.CHM., CALIF.  
 Refs: 1966 Proc. VOL. II pp. 297-298 (additional references)  
 1966 Proc. VOL. II pp. 311-356  
 1967 Proc. VOL. I pp. 53-58  
 1967 Proc. VOL. II pp. 303-319  
 1968 Proc. VOL. I p. 61
  
6. MEXICO INSURANCE PROBLEMS (A6) COMMITTEE Report (Mtg. 29)  
 HON. WALTER S. HOUSEAL, CHM., ALA.  
 HON. RALPH F. APODACA, V.CHM., N. MEX.  
 Refs: 1966 Proc. VOL. I p. 45  
 1966 Proc. VOL. II p. 359  
 1967 Proc. VOL. I p. 59  
 1967 Proc. VOL. II p. 321  
 1968 Proc. VOL. I pp. 63-66
  
7. CIVIL DISORDERS - INSURANCE PROBLEMS (A7) COMMITTEE Report  
 (Mtg. 30)  
 HON. T. NELSON PARKER, CHM., VA.  
 HON. GEORGE M. COWDEN, V.CHM., TEXAS  
 Ref: 1968 Proc. VOL. I pp. 69-78
  
8. Audit Report of Executive Secretary's Office  
 Hon. Robert D. Haase, Wis.  
 Refs: 1965 Proc. VOL. II pp. 271; 301-308  
 1966 Proc. VOL. II pp. 301; 360-363  
 1967 Proc. VOL. II pp. 285; 327-330
  
9. Executive Secretary's Report (Fiscal year 5/31/67 - 6/1/68)  
 Refs: 1967 Proc. VOL. I pp. 65-68  
 1967 Proc. VOL. II pp. 331-334  
 1968 Proc. VOL. I pp. 79-81
  
10. Selection of Executive Secretary  
 Ref: 1968 Proc. VOL. I p. 4 (By-Laws Section 2)
  
11. Any other matter submitted for consideration.

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### EXECUTIVE (A) COMMITTEE Report

The meeting of the Executive (A) Committee was held at 9:00 A.M. Thursday, June 20, 1968 in Ballroom A of the Portland Hilton Hotel, Portland, Oregon.

Special meeting, Jackson Hole, Wyoming: The report of the special meeting of the Executive (A) Committee which was held Monday, March 11, 1968 in the Pink Garter Theatre in Jackson Hole, Wyoming, was received and adopted.



1. To Study Future Sites for NAIC Meetings (A1) Subcommittee: The report of the Subcommittee was received and adopted.
2. Uninsured and Partially Uninsured Non-Regulated Plans (A2) Subcommittee: The report of the Subcommittee was received and adopted.
3. To Study Reorganization and Public Information Matters (A3) Subcommittee: The report, as amended, submitted by Commissioner James L. Bentley, Georgia, acting on behalf of Hon. T. Nelson Parker of Virginia, was received and adopted.
4. Liaison with State Agencies (A4) Subcommittee: The report of the Subcommittee was received and adopted.
5. BLANKS (A5) COMMITTEE: The report was submitted by Commissioner James H. Hunt of Vermont and was received and adopted.
6. MEXICO INSURANCE PROBLEMS (A6) COMMITTEE: The report of the Committee was received and adopted.
7. CIVIL DISORDERS - INSURANCE PROBLEMS (A7) COMMITTEE: The report was submitted by Hon. George M. Cowden on behalf of Hon. T. Nelson Parker, Chairman, Virginia. The report was received and adopted.
8. The Wisconsin Insurance Department submitted an audit report of the Executive Secretary's Office and an audit pertaining to the Non-Admitted Insurers Information Office. Both reports were received and adopted.
9. The Executive Secretary's Report (fiscal year 5/31/67 to 6/1/68) was received and adopted.
11. Other Matters — Under this item the following matters were submitted:

Mr. J. Mack Tarpley, representing the American Land Title Association, read a resolution passed by his Association. A copy of the resolution is attached. Chairman Price advised Mr. Tarpley that the Executive (A) Committee would consider the resolution and report its decision at a later date.

Motion was made that the President of the NAIC address a letter to the Governors of the 50 States urging them to make sure that funds are provided for the Insurance Commissioners, with adequate Staff, to attend meetings of the NAIC and its Committees to the end that the

Insurance Departments of the several States may enhance their regulatory competence and participate fully in the on-going work of strengthening state regulation through leadership of the NAIC. Said motion was seconded and adopted.

Motion was made that the Host Commissioner of the 1968 Regular Meeting of the NAIC in Los Angeles, California, December 2-6, 1968, be instructed to extend an invitation to such meeting to various foreign Commissioners or Supervisors of Insurance. Such invitations should be extended to the Canadian, Mexican, Australian, Philippine, and such other foreign insurance regulatory officials as he (the Host Commissioner) may deem appropriate. Said motion was seconded and adopted.

Commissioner Haase of Wisconsin commented upon proposed legislation by the Congress to regulate welfare and pension plans. The Commissioner stated that his State of Wisconsin was presently regulating such plans and that he hoped that the NAIC would resist and object to any federal legislation attempting to regulate in this area. The Commissioner urged that more States become interested in regulating welfare and pension plans in the public interest; otherwise, federal regulation to a limited degree will occur. Commissioner Haase then moved that the Executive Committee direct the (A2) Subcommittee to study the feasibility and possibility of the States assuming the regulation of welfare and pension funds. Said motion was seconded by Superintendent Stewart and was adopted.

Commissioner Dykhouse made a motion, seconded by Commissioner Barnes, that a Subcommittee be created to study the applicability of data processing techniques to the annual statements. Said motion was adopted along with the proviso that these studies be coordinated with the Blanks Committee.

Commissioner Haase, Chairman of the Variable Annuities Subcommittee, commented on the S.E.C. requirements to keep examination questions for variable annuity agents classified as confidential, and that S.E.C. preferred that such examinations be revised annually. It was suggested that the matter be referred to the Variable Annuities Subcommittee for further consideration.

There being no further business to come before the Executive Committee, the meeting adjourned.

Hon. Ned Price, Chm., Texas; Hon. Richard S. L. Roddis, V.Chm., Calif.; Hon. David J. Dykhouse, Mich.; Hon. Richard E. Stewart, N. Y.; Hon. C. Eugene Farnam, Mass.; Hon. David O. Maxwell, Pa.; Hon. Broward Williams, Fla.; Hon. Robert D. Haase, Wis.; Hon. J. Richard Barnes, Colo.; Hon. Louis T. Mastos, Nev.; Hon. James L. Bentley,

Pres., Ga.; Hon. Charles R. Howell, V.Pres., N. J.; Hon. Ralph F. Apodaca, Secy.-Treas., N. M.

**BE IT RESOLVED** That the President of the American Land Title Association be and he is hereby directed by the Board of Governors of the said American Land Title Association, to appoint a committee composed of six active members, representative of both Sections of the Association to work and cooperate with the National Association of Insurance Commissioners or the appropriate committee or committees thereof, in order to further a more complete understanding of the business of title insurance, to promote sound legislation and regulation, to prevent unsound legislation and to accomplish other desirable, lawful objectives, with the understanding that any undertaking or agreement on behalf of the American Land Title Association shall be subject to ratification by a majority of the Board of Governors or the Executive Committee of the American Land Title Association prior to approval and adoption of such undertaking or agreement.

EXECUTIVE (A) COMMITTEE  
SPECIAL MEETING - EXECUTIVE SESSION  
A G E N D A

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MONDAY, MARCH 11, 1968 2:00 P.M.  
WORT HOTEL JACKSON, WYOMING

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1. To Study Future Sites for NAIC Meetings (A1) Subcom. Report (if any).  
Hon. John Norman Harkey, Chm., Ark.  
Hon. J. Richard Barnes, V.Chm., Colo.
2. Uninsured and Partially Uninsured Non-Regulated Plans (A2) Subcom. Report (if any).  
Hon. J. Richard Barnes, Chm., Colo.  
Hon. Robert D. Haase, V.Chm., Wis.
3. To Study Reorganization and Public Information Matters (A3) Subcom. Report (if any).  
Hon. T. Nelson Parker, Chm., Va.  
Hon. Richard E. Stewart, V.Chm., N. Y.
4. BLANKS (A4) COMMITTEE Report (if any).  
HON. JAMES H. HUNT, CHM., VT.  
HON. RICHARD S. L. RODDIS, V.CHM., CALIF.
5. MEXICO INSURANCE PROBLEMS (A5) COMMITTEE Report (if any).  
HON. WALTER S. HOUSEAL, CHM., ALA.  
HON. RALPH F. APODACA, V.CHM., N. MEX.
6. CIVIL DISORDER - INSURANCE PROBLEMS (A6) COMMITTEE Report (if any).  
HON. T. NELSON PARKER, CHM., VA.  
HON. GEORGE COWDEN, V.CHM., TEX.
7. Any other matter submitted for consideration.

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EXECUTIVE (A) COMMITTEE Report  
Special Meeting — Jackson Hole, Wyoming  
March 11, 1968

A special Meeting of the EXECUTIVE (A) COMMITTEE was held Monday, March 11, 1968 in the Pink Garter Theater in Jackson Hole, Wyoming.

After roll call, which showed a quorum present, the following matters were considered. The agenda arrangement was partially disregarded to accommodate those who had requested the privilege of presenting statements. However, for purposes of future reference, the items considered

are reported in the same sequence as they appear on the prepared Agenda.

1. To Study Future Sites for NAIC Meetings (A1) Subcom.

Chairman Ned Price pointed out that a vacancy existed in the Chairmanship of the (A1) Subcommittee and appointed Vice Chairman, J. Richard Barnes, to the Chairmanship. Commissioner Barnes explained that there had been no meetings of the Subcommittee since the 1967 Regular Meeting, and therefore, no report.

2. Uninsured and Partially Uninsured Non-Regulated Plans (A2) Subcom.

Chairman Barnes stated that he had expected some information from the Advisory Committee, but as yet none had been received.

3. To Study Reorganization and Public Information Matters (A3) Subcom. Report

Chairman T. Nelson Parker read the Report of the 2/8/68 Meeting to which was appended a Resolution and a Budget Comparison. Following a discussion, certain amendments were made to the Resolution. A motion for the adoption of the Report, with the amended Resolution and Budget Comparison appended, was then duly made, seconded and passed. The Report, including the Resolution as amended, and Budget Comparison is attached and made a part of this Report.

4. BLANKS (A4) COMMITTEE

There was no report as there had been no meetings since the NAIC 1967 Regular Meeting.

5. MEXICO INSURANCE PROBLEMS (A5) COMMITTEE

No interim meetings of this Committee have been held, therefore, no report.

6. CIVIL DISORDERS — INSURANCE PROBLEMS (A7) COMMITTEE Report

Chairman Parker read the Report of the Meeting of 2/7/68. On motion duly made, seconded and passed, the Report was adopted. A copy of the Report is attached, and made a part of this Report. A discussion of S3028 followed and statements were made by the following industry representatives:

F. A. Holderman — American Mutual Insurance Alliance  
 Ambrose Kelly — Factory Mutuals  
 M. V. Slevin — American Insurance Association  
 Clyde Cecil — National Association of Independent Insurers

In general, the statements seemed to reflect an agreement in principle with the Advisory Panel Report, but that more study was required to determine whether or not the provision of S3028 were in conformance with the Panel recommendations. In compliance with a request from President Bentley for a consensus as to NAIC's position with reference to S3028, the following were appointed to draft a statement for use by President Bentley:

Honorable Richard S. L. Roddis — California  
 Honorable David J. Dykhouse — Michigan  
 Honorable Richard E. Stewart — New York  
 Honorable T. Nelson Parker — Virginia  
 Honorable Robert D. Haase — Wisconsin

There being no further business to be considered, the Meeting was adjourned.

Hon. Ned Price, Chm., Texas; Hon. Richard S. L. Roddis, V.Chm., Calif.; Hon. David J. Dykhouse, Mich.; Hon. Richard E. Stewart, N. Y.; Hon. C. Eugene Farnam, Mass.; Hon. David O. Maxwell, Pa.; Hon. Broward Williams, Fla. by E. A. Faircloth; Hon. Robert D. Haase, Wis.; Hon. J. Richard Barnes, Colo.; Hon. Louis T. Mastos, Nev.; Hon. James L. Bentley, Pres., Ga.; Hon. Charles R. Howell, V.Pres., N. J.; Hon. Ralph F. Apodaca, Secy.-Treas., N. M.

## To Study Reorganization and Public Information Matters

### (A3) Subcom. Report

A meeting of the Subcommittee To Study Reorganization and Public Information Matters was held on February 8, 1968, at 10:00 A.M., in Chelsea Rooms A & B of the Americana Hotel, New York, New York. A quorum of the Subcommittee was present or represented.

The Chairman explained that the purpose of the meeting was to interview certain applicants for positions with the NAIC when the Central Office is reorganized and to consider the question of State assessments for the operation of the Central Office.

The Subcommittee, along with the members of the NAIC Special Selection Committee, interviewed a number of applicants, most of whom seemed well qualified for a position with our reorganized Central Office. Also it heard from Mr. Robert Dineen, former Superintendent of Insurance for the State of New York and retiring Chairman of the Board of Northwestern Mutual Life Insurance Company. Mr. Dineen disclosed at the conference that he would be willing to accept a position as Consultant for the purpose of establishing and getting into operation a new Central Office that could better serve the needs of the NAIC. For a retainer of approximately \$12,000.00 a year he was willing to give to this work practically his entire working time. He would be available after August 1, 1968, when his active duties with the Northwestern Mutual Life Insurance Company cease, except for occasional work that he would continue doing as a member of the Company's Finance Committee and its Board of Trustees. The idea was that he could in a year or two get the Central Office completely reorganized and then taken over by a full time permanent staff which could accomplish those things the Commissioners of our Country desire it to accomplish.

The Subcommittee, as well as the Special Selection Committee, decided to recommend to the Executive Committee of the NAIC the employment of Mr. Dineen and approval of his plan for reorganization.

No recommendations were made as to the other persons interviewed at this time.

The question of State assessments was discussed and it was determined that the reason why many States had not paid their assessment was that the amount to be paid by each State was assessed after the Legislatures of these States had met. There wasn't any provision made for the assessment in their last year's budget. Those present thought this would be taken care of in these States at the legislative sessions being held

this year. Upon this determination it was decided that nothing should be done at this time in reference to the dues of the various members.

There being no further business, the meeting adjourned.

Hon. T. Nelson Parker, Chm., Va.; Hon. Richard E. Stewart, V.Chm., N. Y.; Hon. Richard S. L. Roddis, Calif.; Hon. J. Richard Barnes, Colo.; Hon. James L. Bentley, Ga.; Hon. Lorne R. Worthington, Iowa; Hon. C. Eugene Farnam, Mass.; Hon. Walter D. Davis, Miss.; Hon. Donald Knowlton, N. H.; Hon. Charles R. Howell, N. J.; Hon. Lee I. Kueckelhan, Wash.

A RESOLUTION (First revision)

WHEREAS, the NAIC now maintains two offices (New York City and Des Plaines, Illinois), housing three functions, (1) the Securities Valuations Function, (New York), (2) the Non-Admitted Insurers Function, (New York) and (3) the Secretary's Function (Des Plaines) and

WHEREAS, the disbursements of the three functions for the fiscal year ending May 31, 1967 are approximately as follows: (1) Valuation Office — \$250,000, (2) Non-Admitted Insurers Office — \$15,000 and (3) Secretary's Office — \$53,000 and

WHEREAS, the revenues for the three offices (for the fiscal year ending May 31, 1967) were (1) Valuation Office — \$220,000, (2) Non-Admitted Insurers Office — \$10,000 and (3) Secretary's Office — \$62,000 and

WHEREAS, the NAIC desires to expand the function of the Secretary's Office so as to include research and related functions, briefing and informational services, as well as liaison with the NAIC Washington Counsel, (certain other functions such as a comprehensive reference library, public relations and educational seminar being deferred until additional experience is acquired under the expanded office) and

WHEREAS, the Des Plaines Office has no research facilities such as law libraries, insurance libraries, academic libraries, and large public libraries, and

WHEREAS, the NAIC would like to obtain some practical experience in the initial period of the new research and related functions before making a final decision as to where these functions should be located permanently, (e.g. New York, Chicago, Washington, or the immediate vicinity thereof), and

WHEREAS, the NAIC has obtained the services of a consultant and Director of Research who would like to function temporarily in Milwaukee, Wisconsin during the shake-down period, and

WHEREAS, this location provides the research facilities unavailable in the Des Plaines area, [and]

[WHEREAS, the NAIC agrees to retire Mr. and Mrs. Tollack under the NAIC retirement plan on or before September 1, 1968 and wishes to authorize their replacement by competent persons at appropriate salary levels,]

NOW THEREFORE BE IT RESOLVED,

(1) that the new administrative service office be established commencing on or about [May 1] *July 1, 1968*,

(2) that the office be located temporarily in the city of Milwaukee until such time as the Executive Committee of the Association determines the need to move it elsewhere,

(3) that the Securities Valuations function and the Non-Admitted Insurers function be continued in a separate office from the administrative service office until such time as the Executive Committee of the Association determines that consolidation would be feasible and desirable,

(4) that the Executive Secretary's office be consolidated with the administrative service office under the latter title in Milwaukee as soon as feasible after the June, 1968 NAIC Annual Meeting in Portland, Oregon,

Note: Matter in [brackets] has been deleted.  
Matter in *italics* has been added.



(5) that Mr. and Mrs. Tollack be retired [and their benefits terminated] at the discretion of the Executive Committee,

(6) that the services of Jon Hanson be obtained as Director of Research at an initial salary of \$16,000 per year, increased to \$18,000 per year, commencing [June 1] *July 1*, 1969, if his services are satisfactory to the Executive Committee, and that the fringe benefits be accorded as in the other NAIC offices,

(7) that the Director of Research be authorized to employ a secretary at a salary approved by the President and Executive Committee Chairman plus the fringe benefits,

(8) that the Director of Research be authorized to employ, if necessary, two other persons who, under his general direction, will primarily assume the type of activities now carried on at the Des Plaines office and their selection and salaries must be approved by the principal officers of the Association,

(9) that no additional employees are to be added to the staff except with the consent of the Executive Committee,

(10) that subject to the approval of the Executive Committee, the Director of Research is authorized to retain consultants for research projects that can be performed most effectively and economically on a retainer basis,

(11) that the Director of Research initially concentrate on the research, briefing and informational services functions,

(12) that the Director of Research is authorized to develop a working relationship with the NAIC Washington Counsel,

(13) that the Association open a checking account in the Marine National Exchange Bank of Milwaukee in the name of and on behalf of the Association,

(14) that the Director of Research be authorized to sign on behalf of the Association checks, receipts or orders for the payment or withdrawal of funds deposited in the checking account or deposited to the credit of the Association in the Marine National Exchange Bank of Milwaukee, with respect to the payment of bills, including salaries and moving expenses, related to the day-to-day operation and the equipping of the new expanded administrative service office subject to the over-all budget limitations set forth herein, but before the Director of Research may exercise these powers, he must provide a bond to the NAIC,

(15) that the attached budget for the enlarged office and staff be approved,

(16) that the services of Robert Dineen be retained as consultant to assist in the establishment and operation of the new administrative service office at a fee of \$12,000 per year, effective September 1, 1968.

Note: Matter in [brackets] has been deleted.

Matter in *italics* has been added.

## BUDGET COMPARISON

	Present Executive Secretary's Office	New Staff Executive Secretary's Office	New Administrative Service Office	Combined Operations Office
Salaries	\$26,500	\$20,500	\$ 24,500	\$ 39,500
Benefits				
Employees	6,900	5,200	6,200	10,000
Rent	4,200	4,200	4,000	11,000
Telephone	1,200	1,200	2,000	2,500
Postage	2,000	2,000	1,000	3,000
Travel	1,000	1,000	4,000	4,500
Office Supplies	400	400	1,100	1,500
Books & Periodicals	0	0	1,000	1,000
Misc. Expense	1,000	1,000	1,500	1,500
Furniture				
Machinery	2,200	600	4,700	4,400
Proceedings	11,100	11,100	0	11,100
Transcripts	1,800	1,800	0	1,800
Total	58,300	49,000	50,000	91,800
Consultation Fee	0	2,000	12,000	12,000
Loss on Non- Admitted Office	7,400	7,400	0	7,400
GRAND TOTAL	\$65,400	\$58,400	\$ 62,000 \$ 58,400 \$120,400	\$111,200 \$ 0 \$111,200

Note the 1967-68 projected budget for the Executive Secretary's Office is \$99,000. Since the reasons for this substantial increase are not clear, the projections may need to be revised upwards. If the new office commences May 1, 1968, adjustments will have to be made to reflect a thirteen-month year.

CIVIL DISORDERS — INSURANCE PROBLEMS  
COMMITTEE Report

A meeting of the COMMITTEE to study CIVIL DISORDERS — INSURANCE PROBLEMS was held on February 7, 1968, at 10:00 A.M., in the Royal Box Room of the Americana Hotel, New York, New York. All members of the COMMITTEE were present or represented.

The Chairman explained that the purpose of the meeting was to discuss with industry the Report by The President's National Advisory Panel on Insurance in Riot-Affected Areas, which was recently released by the Honorable Richard H. Hughes, Governor of New Jersey, Chairman of this Panel.

The Chairman then called upon various members of industry that desired to be heard. The following persons spoke to the COMMITTEE and stated the position of his organization or others that he represented:

Mr. T. Lawrence Jones, President, American Insurance Association

Mr. Vestal Lemmon, General Manager, National Association of Independent Insurers

Mr. Paul S. Wise, General Manager, American Mutual Insurance Alliance

Mr. Thomas C. Morrill, Vice President, State Farm Mutual Insurance Company

Honorable Frank M. Wozencraft, Assistant Attorney General of the United States, Member of the President's Panel on Insurance in Riot-Affected Areas

After hearing from the persons noted above and giving anyone else an opportunity to be heard, the COMMITTEE went into Executive Session. In the Executive Session the COMMITTEE adopted and approved the following statement:

The recently released Report of the President's National Advisory Panel on Insurance in Riot-Affected Areas entitled "Meeting The Insurance Crisis Of Our Cities" is a scholarly and comprehensive study of central city insurance problems. We agree in principle with the findings and analysis of the Report.

The National Association of Insurance Commissioners for many years has called attention to insurance market constrictions in central

city areas. The Association has recommended inspection plans, pools and federal tax deferrals for catastrophe reserves to meet the problem. We are pleased that the National Advisory Panel has included these steps among its recommendations.

The Report clearly recognizes the necessity for an adequate and stable supply of basic insurance coverages for the preservation and future growth of a viable economic and community life in urban areas. Further, it recognizes the primary right and responsibility of the private insurance industry to supply the demand for such coverages on a fair and economically sound basis. The order of the Panel's proposals is significant. Hence, we call upon all responsible industry groups to move immediately to come forward with concrete and specific plans for the implementation of the proposals outlined in the first two portions of the Panel's recommended program, that is, the creation of "FAIR Plans," being major expansions of the urban area inspection plan concept, and the creation of state pools or other facilities wherever needed to accommodate insurable properties declined under the FAIR Plans.

Like the Panel, we recognize that, at least for such temporary period until civil conditions stabilize or develop a predictable and controllable pattern and until other adequate reserves can be developed, it will be in the public interest that insurers be protected by reinsurance or otherwise against catastrophic losses arising from riots and civil disorders. In this connection, we agree with the following statement by the Panel:

"We believe that a successful program can be designed to operate within the context of the existing structure of the insurance industry and the existing pattern of state regulation and taxation of the insurance industry.

"We believe also that federal measures should support rather than supplant local efforts. Action by the federal government should encourage and assist those with frontline responsibilities.

"We are convinced that the solution of the insurance problem of the center cities lies in the cooperative efforts of all who are involved. No single interested segment — the insurance industry, local, state and federal governments, or the residents and businessmen of the urban core — can, acting alone, ameliorate the complex and interdependent conditions that cause this problem.

"All must accept a measure of responsibility. By doing so, the insurance crisis can be met.

“The principal alternative to this approach is for government itself to provide insurance directly. We believe that so marked a departure from the free enterprise insurance system is unjustified at this time. We have confidence in the strength of the insurance industry and the abilities of the state insurance departments. We feel that they can, with limited federal assistance, meet the challenge posed by the critical insurance needs of our center cities.”

The COMMITTEE directed that the Chairman and/or President of the National Association of Insurance Commissioners release this statement to the press and that a copy of this report and the statement be sent to all members of the Executive Committee of NAIC.

There being no further business, the meeting adjourned.

Hon. T. Nelson Parker, Chm., Va.; Hon. George M. Cowden, V.Chm., Texas; Hon. Richard S. L. Roddis, Calif.; Hon. John F. Bolton, Jr., Ill.; Hon. David J. Dykhouse, Mich.; Hon. Richard E. Stewart, N. Y.; Hon. William R. Morris, Ohio.

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To Study Future Sites for NAIC Meetings (A1) Subcom. Report  
(Mtg. #17)

The Subcommittee to Study Future Sites for NAIC Meetings met in Galleria 2 of the Portland Hilton at 1:30 p.m., Monday, June 17, 1968. A quorum was present. The Chairman reviewed the dates and places which have been approved and committed in previous meetings.

It was moved, seconded and approved that the December 1971 meeting scheduled for Florida be headquartered in the Fontainebleau Hotel, November 28th to December 3rd, 1971. This decision was based on the detailed survey of three hotels which bid in competition. The survey was made by Chairman Barnes and the content of the survey results have been presented to the Subcommittee Members.

It was moved, seconded and approved that the Hilton Hotel in Denver, Colorado, be established as the headquarters for the 1972 Meeting with dates of June 11th through June 16th.

Las Vegas, Nevada, previously approved for the December, 1973 Meeting, proposed that the now under construction International Hotel be tentatively established as the headquarters hotel for the first full week of December 1973. It was moved, seconded and approved that this be so.

Pending invitations were discussed as follows. San Francisco for June 2nd through 7th, 1974, was proposed by Richard S. L. Roddis, with further comments by William Jenkinson, Assistant Convention Manager, San Francisco Convention and Visitors Bureau; and Fred Drexler, President of Industrial Indemnity. Either the Nob Hill Hotels or the San Francisco Hilton would be suggested as headquarters hotel. Salt Lake City renewed their invitation, suggesting the Hotel Utah for June, 1975. This invitation was conveyed by Commissioner C. N. Ottosen. Pedro Reyner, Director of Insurance for the Republic of Mexico, and Dr. Legaspi, Minister of Tourism for the Republic of Mexico, conveyed an invitation for December, 1974 or any prior December which becomes vacant due to unforeseen circumstances. It was moved, seconded and unanimously approved that the three invitations, San Francisco, Salt Lake City and Mexico, be accepted.

In conclusion, the Chairman reminded all concerned of the recommended basic criteria in selecting sites as approved in the December, 1965 NAIC Meeting and published on Page 52 of Volume I, 1966 Proceedings. Comment was also made that numbering of Conventions was to have

been discontinued and reference should be made only to the year in order to avoid confusion with the Centennial celebration in 1971.

There being no further business, the meeting was adjourned.

Hon. J. Richard Barnes, Chm., Colo.; Hon. Broward Williams, Fla.;  
Hon. Joseph G. Wood, Ind.; Hon. C. N. Ottosen, Utah; Hon. James  
H. Hunt, Vt.; Hon. T. Nelson Parker, Va.

Note: NAIC Future Meeting Sites added for information.

#### NAIC FUTURE MEETING SITES

##### ANNUAL MEETINGS (June)

##### REGULAR MEETINGS (December)

1968

REFS: 1968 REGULAR MEETING  
DATES: 12/2/68 to 12/6/68  
HOTEL: Century Plaza Hotel, Hdqtrs.  
CITY: Los Angeles, California  
REFS: 1966 Proc. VOL. I p. 51  
1966 Proc. VOL. II p. 302

1969

FOR: 1969 ANNUAL MEETING	FOR: 1969 REGULAR MEETING
DATES: 6/16/69 to 6/20/69	DATES: 12/1/69 to 12/5/69
HOTEL: Bellevue-Stratford Hotel, Hdqtrs.	HOTEL: Roosevelt Hotel, Hdqtrs.
CITY: Philadelphia, Pennsylvania	CITY: New Orleans, Louisiana
REF: 1965 Proc. VOL. II pp. 277-279	REF: 1966 Proc. VOL. I p. 51

1970

FOR: 1970 ANNUAL MEETING	FOR: 1970 REGULAR MEETING
DATES: 6/15/70 to 6/19/70	DATES: 12/14/70 to 12/18/70
HOTEL: Sheraton-Cleveland Hotel, Hdqtrs.	HOTEL: Palmer House, Hdqtrs.
CITY: Cleveland, Ohio	CITY: Chicago, Illinois
REF: 1966 Proc. VOL. I p. 51	REFS: 1966 Proc. VOL. II p. 303 1967 Proc. VOL. II p. 287

1971

FOR: 1971 ANNUAL MEETING	FOR: 1971 REGULAR MEETING
DATES: 6/13/71 to 6/18/71	DATES: 11/28/71 to 12/3/71
HOTEL: Americana Hotel, Hdqtrs.	HOTEL: Fontainebleau Hotel, Hdqtrs.
CITY: New York, New York	CITY: Miami Beach, Florida
REFS: 1966 Proc. VOL. I p. 51 1967 Proc. VOL. II p. 287	REF: 1967 Proc. VOL. II p. 287

1972

FOR: 1972 ANNUAL MEETING	FOR: 1972 REGULAR MEETING
DATES: 6/11/72 to 6/16/72	DATES: To be determined.
HOTEL: Denver Hilton Hotel, Hdqtrs.	HOTEL: To be determined.
CITY: Denver, Colorado	CITY: Atlanta, Georgia
REF: 1967 Proc. VOL. II p. 287	REF: 1967 Proc. VOL. II p. 287

1973

FOR: 1973 ANNUAL MEETING	FOR: 1973 REGULAR MEETING
DATES: 6/18/73 to 6/22/73	DATES: 12/3/73 to 12/7/73
HOTEL: To be determined.	HOTEL: International Hotel
CITY: Baltimore, Maryland	CITY: Las Vegas, Nevada
REF: 1967 Proc. VOL. II p. 287	REF: 1968 Proc. VOL. I p. 53

1974

FOR: 1974 ANNUAL MEETING	FOR: 1974 REGULAR MEETING
DATES: 6/2/74 to 6/7/74	DATES: To be determined.
HOTEL: To be determined.	HOTEL: To be determined.
CITY: San Francisco, California	CITY: Mexico City, Mexico
REF: Meeting 6/17/68	REF: Meeting 6/17/68

1975

FOR: 1975 ANNUAL MEETING  
DATES: To be determined.  
HOTEL: Hotel Utah  
CITY: Salt Lake City, Utah  
FOR: Meeting 6/17/68

## Uninsured and Partially Uninsured Non-Regulated Plans

## (A2) Subcom. Report (Mtg. #21)

The (A2) Subcommittee on Uninsured and Partially Uninsured Non-Regulated Plans met in the Galleria Room of the Hilton Hotel at 2:30 P.M., Monday, June 17, 1968. A quorum was present.

The Chairman presented a summary of comments regarding the various inquiries which had been made by the Committee of Organizations and Associations which have had an interest in the subject. A copy of his comments is attached hereto and made a part of this report.

Mr. Edward E. Mack, Jr., Chairman of the National Foundation of Health, Welfare, and Pension Plans, Inc., presented a statement of the position of his organization. A copy of his statement is attached hereto and made a part of this report.

Stan Du Rose, Deputy Commissioner from Wisconsin, summarized the memorandum comments on HR 5741 as submitted by Commissioner Haase of Wisconsin to the House General Labor Subcommittee on May 14, 1968, and also the Wisconsin Law, Chapter 211, on Employees Welfare Plans. A copy of this memorandum and of the law is attached hereto and made a part of this report.

Clark Bryan of the American Life Convention stated that ALC's policy position is that since the plans, which are the subject of this Subcommittee's discussions, are presently federally regulated, state laws relating to the subject should be repealed to avoid dual regulation.

In the Executive Session it was moved, seconded, and unanimously voted that this Subcommittee should ask for instructions from the Executive Committee as to whether or not the NAIC should establish a policy position on the federal aspects of regulation of uninsured and partially uninsured non-regulated plans. There being no further business, the Subcommittee adjourned.

Hon. J. Richard Barnes, Chm., Colo.; Hon. Robert D. Haase, V.Chm., Wis.; Hon. Robert D. Preston, Ky.; Hon. C. Eugene Farnam, Mass.; Hon. T. Nelson Parker, Va.

## Summary Comments Regarding Uninsured and Partially Uninsured Non-Regulated Plans

## (A2) Subcommittee

The (A2) Subcommittee has been in contact with a substantial number of interested parties and organizations which should be interested in the subject of this Committee. At least ten organizations or individuals have been contacted by the Committee Chairman to inform them of the subject matter of the Committee discussions and to solicit their comments and suggestions so that the Committee may have the broadest possible area of assistance and base of information in its



deliberations. All have been invited to attend the Portland Meeting of the NAIC in June and to make comments if they so desire.

The organizations contacted have included the Trust Division of the American Bankers Association, the American Bar Association, the American Institute of CPA's, the Conference of Actuaries in Public Practice, the National Foundation of Health, Welfare and Pension Plans, Inc., the Pension Research Council, the Committee of State Accreditation of American Academy of Actuaries, the U. S. Department of Labor, and certain interested individuals. Their responses may be summarized as follows.

The American Academy of Actuaries: Recommends that all Uninsured and Partially Uninsured Non-regulated Plans be required to have a periodic valuation and review made by a qualified actuary. They further suggest that membership in the Academy be accepted as evidence of such qualification.

The American Bar Association: Seemed to be primarily interested in the draft of legislation and only wanting to review any legislation which may have been drafted.

The Society of Actuaries: States that since "Their activities are limited to matters that are clearly within the professional competence of actuaries, . . . (we) . . . do not have a position on the subject such as this."

The American Institute of CPA's: Has recently appointed a Committee to consider the need for authoritative literature on the accounting and auditing aspects of health, welfare and pension plans. They concur that the public should have some assurance that the funds under the plans are being handled properly. While they indicate a desire and willingness to cooperate, they felt no need for them to make a presentation before the NAIC Committee until NAIC's approach has been solidified.

Conference of Actuaries in Public Practice: Expressed a desire to cooperate with NAIC in any way in which they could be helpful. Their "Committee to Study Problems in the Pension Field" under the Chairmanship of Frank L. Griffin, Jr. of the Wyatt Company has been designated as the official body of the Conference to correspond with the NAIC and to work with us. The Conference seems to be primarily concerned to be assured that if actuarial certification is included in the regulations or laws, that the Fellows of the Conference be specifically recognized as individuals qualified to certify.

Mr. Frank L. Griffin, Jr. of the Wyatt Company indicates that in his opinion the need for welfare fund regulation has been grossly exaggerated. He feels that the imposition of inflexible standards of valuation (including actuarial assumptions as well as valuation methods) would clearly be unsuitable in the field of Pension Plans covering employees of private employers. He feels that no single standard can possibly fit the circumstances of different plans at a given moment of time or a single plan over a period of time. More over, he feels that the problems of keeping legislation up-dated, if such legislation were passed, would be almost insurmountable. Mr. Griffin delivered a rather outstanding paper on March 11, 1968 before the AMA Seminar in New York City. This paper is titled "Public Influences Affecting the Future of Private Pensions." This paper is well worth studying by all interested in the subject matter of the (A2) Subcommittee.

Mr. Kenneth H. Ross of Huggins and Company, Inc., a member of the Board of Directors of the Conference of Actuaries in Public Practice, filed a separate report indicating that he did not feel that the states should undertake the supervision and regulation of Uninsured Plans for the protection of the general public. Among his reasons for thinking that such regulation was undesirable were the following:

1. Federal Government at the present time has laws and regulations relating to the supervision of pension and profit sharing plans and he feels there is every indication that such supervision and regulation will be sharply extended before long. (H.R. 5741 is currently under consideration along this line.)
2. All but a fraction of the assets of the Uninsured Plans, in the opinion of Mr. Ross, are held by banks and trust companies acting as trustees. As such, he feels that there is adequate supervision and control by appropriate state and federal regulatory agencies.
3. Corporations with these plans are almost invariably subject to audit by members of the American Institute of CPA's and Opinion No. 8 of their Accounting Principles Board has done much to standardize the treatment of Pension costs in the annual statement of these corporations.

The National Foundation of Health, Welfare and Pension Plans, Inc.: Has shown a great deal of interest. It is anticipated that they will make a presentation of their position at the (A2) Subcommittee Meeting in Portland the week of June 17th.

The Pension Research Council: Took up the matter at their meeting on April 10, 1968. Because they felt that the (A2) Subcommittee was not limited to pension plans, it was their feeling that there is no real problem to be considered from their standpoint. They feel that there is in fact no problem from the standpoint of protecting the interests of pension plan participants. They recognize that various states have other concerns, including the actual or potential of premium tax law revision, but were not in a position to judge the merits of these other concerns.

J. RICHARD BARNES, C.L.U.  
Chairman

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Statement of

Edward E. Mack, Jr., Chairman of National Foundation of  
Health, Welfare, and Pension Plans

as presented to the NAIC (A2) Subcommittee on Uninsured and  
Partially Uninsured Non-Regulated Plans

The National Foundation of Health, Welfare, and Pension Plans is a national non-profit educational association dedicated to more efficient and effective management of jointly trusted fringe benefit funds through the exchange of information and the education of trustees administrators, and the professionals who serve joint trusts.

The membership of the Foundation includes most of the trustees of the funds which have been established in accordance with the Labor-Management Relations Act of 1947. These funds amount to hundreds of millions of dollars. Many millions of people are beneficiaries of these funds.

In general, we are vitally interested in most of the subject matter being considered by your committee. If appropriate we would like to have a closer working relationship with your committee. We believe that much could be gained through the exchange of information and the education of each group by the other.

Specifically, at this time we will focus on one point — the size of the premium tax on insured fringe benefits. We have no axe to grind for insured, self-insured, or partially insured plans. All types are represented by our membership. We, of course, do not represent any special interest group among the purveyors of the various methods of providing fringe benefits. We cannot at this time be a legislative advocate.

We can, however, express our strong conviction that the premium tax on insured fringe benefits should be of a size to produce sufficient dollars to adequately regulate such benefits and no greater. That the private Health and Welfare funds and the private pension funds should be taxed so as to produce millions of dollars of general revenue for the various states is to us incomprehensible and totally unfair to the millions of beneficiaries of such funds.

Incidentally, we submit that the size of the current premium tax is the real heart of the problems facing your committee — that if the tax were sufficient only to provide funds for regulation, the other problems would be mitigated or disappear.

We know something of the political and financial pressures of the states. However, we believe that fully informed legislators would support a reduction.

Our hope is that a tax sufficient only to provide funds for regulation would be a very small fraction of the current tax — certainly less than the  $\frac{1}{2}$  that has been considered in the past.

There are many who feel that the life of the private and fringe benefit plan is seriously threatened by the expansion of federal plans. The efficient and economical operation of the private plan is under attack. The current premium tax on insured fringe benefits is a great weight around the neck of the private state regulated plans.

## Comments on H.R. 5741

For House General Labor Subcommittee

By Robert D. Haase, Commissioner of Insurance

State of Wisconsin

The Insurance Department of the State of Wisconsin has been regulating employe welfare funds since 1957 under a law similar to that proposed at the federal level in H.R. 5741. A description of our experience, problems, and conclusions might be helpful to your committee in your deliberations.

Under our law we receive registration statements on all funds covering one or more Wisconsin employes. We maintain document files and receive Annual Statement filings from all employe welfare funds covering 26 or more Wisconsin employes. A trust or a deposit administration type group annuity comprises a fund under our law. Unlike the federal disclosure act of 1958, we do not have jurisdiction over "plans" operating without a "fund." Unlike the few other states involved in employe welfare fund regulating, we have jurisdiction over both "Taft-Hartley" (union-employer trustee) funds and single employer funds, whether corporate trustees or individual trustees hold the assets. We also have jurisdiction over trustee, association-operated, group insurance programs and employe mutual benefit associations providing employe welfare benefits.

The following table shows the number of funds filing Annual Statements with our office during the year ended December 31, 1967, classified by type of benefit. Funds are further classified by location of the employer. This generally is determined by the location of the home office or main office of the employer. However, in some cases we have classified a fund as located in Wisconsin where the home office of the employer is in another state but the fund covers only employes in a Wisconsin plant or office.

Type of Benefit	Number of Funds		
	Funds Located		
	In Wisconsin	Outside Wisconsin	Total
Pension	533	243	776
Profit-Sharing Retirement	482	45	527
Savings	22	27	49
Health and Welfare	131	57	188
Group Life Insurance	13	20	33
Supplemental Unemployment Benefits	19	15	34
Vacation	27	—	27
Total	1,227	407	1,634

In addition to the 1,634 funds tabulated in the above table, 2,212 additional funds, covering fewer than 26 Wisconsin employes, were registered with our office at December 31, 1967 and are subject to our jurisdiction. All funds covering Wisconsin employes are subject to our disclosure provisions.

Since our fund examination program began in 1958, we have made about 1,000 fund examinations. Under our usual procedure, department examiners conduct examinations of "Taft-Hartley" or association operated funds. Other funds are examined by certified public accounting firms in accordance with examination programs developed by our office and the State Society of Certified Public Accountants. Where actuarial valuations are required, the actuarial consultant serving the fund is requested to complete our Actuarial Report form. Based on this and other information we develop an opinion on the actuarial progress being made by the fund. We examine each fund located in Wisconsin about every five to seven years.

At our request, the 1967 Wisconsin legislative session strengthened our law so we clearly have authority over fund investments, trustee fiduciary conduct, and the actuarial status of a fund. Although our law is arranged much differently, we were surprised to discover that the federal regulatory activity proposed by H.R. 5741 is very similar to our authority over Wisconsin funds. In addition, we have the duty of making the fund examinations described above.

My comments on H.R. 5741 therefore are not critical of the substance of the regulation that would be imposed. But you should be aware of the enormous task

H.R. 5741 places with the federal government. I suggest that it will be beneficial to all if the federal government would assume jurisdiction over only those funds whose operations are not subject to state law and regulation at least as stringent as that of federal law. I know that at the present time Wisconsin, New York and several other states have good state statutes and are doing a very credible job in the administration and enforcement of such statutes.

To provide your committee with information on the number of funds, number of employees covered, and total assets of the funds under our jurisdiction, we have prepared the following tables. Table 1 provides information for those funds located in Wisconsin and with no participants in any other state. Table 2 gives information for Wisconsin funds having participants both within and outside Wisconsin. Table 3 gives information for funds located in other states but with participants in Wisconsin. Table 4 is the total of Tables 1, 2 and 3 and is the summary of all funds having participants in Wisconsin. The tables report data for all funds filing Annual Statements with our office during the year ended December 31, 1967. As noted earlier, Annual Statement filings are required from all funds covering 26 or more Wisconsin employees.

Table 1

Funds Located in Wisconsin Covering Only Wisconsin Employees			
Type of Benefit	Number of Funds	Number of Participants	Total Assets
Pension	388	178,567	\$ 282,386,465
Profit-Sharing Retirement	368	36,548	156,931,321
Savings	15	4,248	8,905,024
Health and Welfare	95	72,675	12,499,621
Group Life Insurance	13	3,487	275,708
Supplemental Unemployment Benefits	12	3,845	902,643
Vacation	23	29,454	4,649,811
<b>Total</b>	<b>914</b>	<b>328,824</b>	<b>\$ 466,550,593</b>

Table 2

Funds Located in Wisconsin Covering Employees in Both Wisconsin and Other States				
Type of Benefit	Number of Funds	Number of Participants		Total Assets
		Employed in Wisconsin	Employed Outside Wisconsin	
Pension	145	135,081	82,416	\$ 804,875,532
Profit-Sharing Retire.	114	57,903	15,123	259,231,541
Savings	7	11,253	8,260	29,317,472
Health and Welfare	36	38,575	9,037	2,581,589
Group Life Insurance	—	—	—	—
Supplemental Unemployment Benefits	7	31,643	11,942	8,724,180
Vacation	4	756	62	204,058
<b>Total</b>	<b>313</b>	<b>275,216</b>	<b>126,840</b>	<b>\$1,104,934,372</b>

Table 3

Funds Located Outside Wisconsin Covering Employees in Both Wisconsin and Other States				
Type of Benefit	Number of Funds	Number of Participants		Total Assets
		Employed in Wisconsin	Employed Outside Wisconsin	
Pension	243	100,523	5,137,339	\$19,599,673,031
Profit-Sharing Retire.	45	12,238	379,988	3,033,791,306
Savings	27	5,624	490,191	1,918,639,395
Health and Welfare	57	20,015	666,213	96,806,581
Group Life Insurance	20	4,062	134,116	5,385,028
Supplemental Unemployment Benefits	15	16,527	901,368	266,430,163
<b>Total</b>	<b>407</b>	<b>158,989</b>	<b>7,709,215</b>	<b>\$24,970,725,504</b>

Table 4

All Funds Covering Wisconsin Employees  
(Filing Annual Statements with Wisconsin)

Type of Benefit	Number of Participants			Total Assets
	Number of Funds	Employed in Wisconsin	Employed Outside Wisconsin	
Pension	776	414,171	5,219,755	\$20,686,935,028
Profit-Sharing Retire.	527	106,689	395,111	3,499,954,168
Savings	49	21,125	498,451	1,956,861,891
Health and Welfare	188	131,265	675,250	111,887,791
Group Life Insurance	33	7,549	134,116	5,660,736
Supplemental Unemployment Benefits	34	52,020	913,310	276,056,986
Vacation	27	30,210	62	4,853,869
<b>Total</b>	<b>1,634</b>	<b>763,029</b>	<b>7,836,055</b>	<b>\$26,542,210,469</b>

The above tables indicate that the operations of a very substantial proportion of the funds involves only participants located in Wisconsin. Our experience indicates that state examinations are essential in the regulation of comparatively small funds covering between 25 to about 200 employees because of informal operating procedures followed by many funds of this size. Funds covering fewer than 26 participants are in need of some minimum level of regulation which can easily be accomplished at the state level by local state authorities. These funds are exempt from any Federal jurisdiction under the present law and that proposed by H.R. 5741.

In connection with the present language of H.R. 5741, we assume Section 14, with the enforcement provisions in Section 9, charges the Secretary of Labor with the responsibility of investigating complaints of fund trustees not conducting their affairs in a proper fiduciary manner. H.R. 5741 emphasizes investment and compensation conflict of interest problems. Our experience indicates that most questions will arise from another area — the correctness of benefit determinations. This kind of question is difficult to process and resolve.

As fund participants are becoming aware of our jurisdiction, inquiries have been increasing from fund participants concerning their benefit payments. Their questions primarily concern whether trustees have properly interpreted fund rules. They involve questions of reasons for termination of employment, method used to compute benefits, and eligibility for benefits. On each complaint we have to review the specific provisions in the plan and trust agreement under which that particular fund operates and usually correspond with fund trustees, administrators, insurance companies and others to attempt to ascertain the facts in the specific case of the complaining fund participant. Until this procedure is completed, we are unable to determine whether fund trustees have acted in a proper fiduciary capacity. On completion of our review we either resolve the matter (if necessary by resorting to our authority under the law) or advise the complainant that the question is one which only a court can decide.

Our experience indicates that in most cases fund participants are extremely reluctant to complain about their fund to their employer or fund trustees. We believe the Secretary of Labor will be overwhelmed with complaints from fund participants under the authority vested with the Secretary in H.R. 5741. We question whether these complaints can be processed from one central office in Washington, D. C. We assume the volume of complaints and the specialized nature of each, involving a review of the plan and trust agreement governing the plan, would make it essential for the Department of Labor to build up large staffs in regional offices which would maintain files of current plans and trust agreements on each fund covering 26 or more participants.

We would also like to direct your attention to the point that the bill apparently requires an annual audit of all funds covering 26 or more participants covered by the Act. Our experience indicates that an annual audit, particularly for smaller funds, is frequently not too valuable. In some cases the auditor providing the report serves as one of the trustees of the fund or has other responsibilities to the fund or employer so no independent audit is accomplished. In addition, the usual balance sheet type audit frequently does not include verification that participant accounts are properly maintained in a profit sharing retirement fund or that benefit computations are accurate or eligibility records adequate in all types of funds.

Additional consideration should also be given to Section 14(b)(3) which apparently would have the effect of excluding from jurisdiction any pension plan covering between 26 and 100 participants where the assets of the plan are being maintained by a deposit administration type contract with an insurance company. We assume that any such plan is little different from a plan of equal size where fund assets are held by a corporate trustee. Both are considered funds under the Wisconsin law. Our experience indicates that in some cases deposit administration type contracts require more supervisory attention from a governmental agency than bank trustee plans.

I strongly urge that consideration be given to enactment of legislation that would preserve the right of the several states to enact and enforce comparable state laws. I respectfully call to your attention the March 14, 1967 report by The Comptroller General on the Review of Certain Activities Related to Administration and Enforcement of the Reporting and Bonding Provisions of the Welfare and Pension Plans Disclosure Act and the Labor-Management Reporting and Disclosure Act of 1959. This report documents the extreme difficulty that a federal agency has and would have in attempting to effectively administer and enforce a regulatory enactment such as H.R. 5741. As Wisconsin has demonstrated, states have the ability and capacity to effectively accomplish such needed regulation of pension and welfare funds.

I appreciate the opportunity to submit this statement for your consideration. A copy of our Wisconsin employe welfare fund law is attached. If you have any questions on our law, procedures, or opinions, we will be happy to supply any additional information you desire.

May 14, 1968

CHAPTER 211.  
EMPLOYEE WELFARE FUNDS

As amended by Chapters 43 and 309, Laws of 1967

211.01 Declaration of policy.	211.11 Annual statements by insurance companies, service plans and corporate trustees and agents.
211.02 Definitions.	211.12 Employer payments to employe welfare funds.
211.03 Registration.	211.13 Regulation under other laws.
211.04 Examinations; authorization.	211.14 Compliance, enforcement and penalties.
211.05 Examinations; conduct.	211.15 Injunctions.
211.06 Examinations; publication.	211.16 Advisory council.
211.07 Examinations; expenses.	211.17 Construction.
211.08 Annual statement to commissioner.	
211.09 Special statements to commissioner.	
211.10 Reports to employers and employes.	

**211.01 Declaration of policy.** It is declared to be the policy of this state that employe welfare funds are of great benefit to employes and their families and that their growth should be encouraged; that the establishment and management of such funds vitally affect the well-being of millions of people and are in the public interest; and that such funds should be supervised by the state to the extent necessary to protect the rights of employes and their families, without imposing burdens upon such funds which might discourage their orderly growth and without duplicating the supervisory responsibilities presently vested in any state agencies.

**211.02 Definitions.** As used in this chapter, unless the context requires otherwise:

(1) "Employe welfare fund" means any trust fund or other fund established or maintained jointly by one or more employers together with one or more labor organizations, solely by any employer or labor organization or jointly by employers or jointly by labor organizations, whether directly or through trustees, to provide employe benefits, by the purchase of insurance or annuity contracts or otherwise, and to which is paid or contracted to be paid anything, other than income from investments of such fund, by or on behalf of any employer doing business in this state or for the benefit of any persons employed in this state.

(2) "Employe benefits" means one or more benefits or services for employes or their families or dependents, or for both, including, but not limited to, medical, surgical or hospital care or benefits, benefits in the event of sickness, accident, disability or death, benefits in the event of unemployment, or retirement benefits.

(3) "Trustee" means any person, firm, association, organization, joint stock company or corporation, whether acting individually or jointly and whether designated by that name or any other, who or which is charged with or has the over-all management of any employe welfare fund.

(4) "Commissioner" means the state insurance commissioner.

**211.03 Registration.** The trustee of every employe welfare fund which covers any person employed in this state shall register such fund with the commissioner within 3 months after it becomes subject to this chapter. The registration shall be in such form and shall contain such information relating to the organization, operations and affairs of such fund as is prescribed by the commissioner.

**History:** 1961 c. 225.

**211.04 Examinations; authorization.** (1) The commissioner may examine into the affairs and actuarial status of any employe welfare fund as often as he deems it necessary, and to that end he may establish regular programs of examinations of funds at such intervals as he determines.

(2) The trustees of every employe welfare fund shall be responsible for the maintenance of accurate records of its books and accounts in conformance with generally accepted accounting principles.

**History:** 1961 c. 225.

**211.05 Examinations; conduct.** (1) Whenever, pursuant to this chapter, the commissioner determines to examine the affairs of any employe welfare fund he shall make an order indicating the scope of the examination and may, without regard to the classified service, appoint as examiners one or more competent persons not employed by the trustees of such fund or interested in such fund. A copy of such order shall, upon

**Note:**  
Matter in *italics* is added.

demand and before the examination begins, be exhibited to at least one of the trustees of the fund whose affairs are to be examined. Any examiner authorized by the commissioner shall have convenient access at all reasonable hours to the books, records, files, assets, securities, and other documents of such employe welfare fund including those of any affiliated or subsidiary fund thereof, which are relevant to the examination. The commissioner and anyone designated by him may administer oaths and examine under oath the trustees of such fund and their officers, agents and employes and any other persons regarding any matter relevant to the examination.

(2) In conducting an examination of any employe welfare fund, in lieu of the procedures otherwise required by this chapter, the commissioner may utilize any appropriate procedures which will safeguard the best interests of participating employes and will fulfill the policy of this chapter. To this end, he may require the trustees or sponsoring employer to furnish him with a report of examination of such fund by a certified public accountant and reports by fund consultants in such form as he requires.

(3) In connection with any examination, the commissioner may, without regard to the classified service, appoint one or more competent persons as appraisers with authority to appraise any real property or any interest therein which, as security or otherwise, may constitute a part of the assets of any employe welfare fund. The report of such appraiser shall be a supplement to the report of the examiner or examiners in charge.

**History:** 1961 c. 225.

**211.06 Examinations; publication.** (1) Pending or after an examination the commissioner shall not make public nor shall he permit to become public any financial statement, report or finding affecting the status, standing or rights of any such employe welfare fund, until a copy thereof has been served upon such employe welfare fund, nor until such employe welfare fund has been afforded a reasonable opportunity to answer any such financial statement, report or finding and to make such showing in connection therewith as it may desire.

(2) In any action or proceeding against the trustees of any employe welfare fund, required to register under this chapter, or against their officers, agents or employes, such report, or any part thereof, if published by the commissioner, shall be admissible in evidence.

(3) The commissioner may assemble and file for public inspection such information covering forms of trust indentures in use, commission and fee schedules adopted by insurers and compensation paid to trustees of employe welfare funds and such other matters affecting the establishment and administration of such funds as, in his opinion, are in the public interest.

**211.07 Examinations; expenses.** (1) The expenses of every examination of the affairs of any employe welfare fund required to register under this chapter, including any appraisal of real property, shall be borne and paid by the employe welfare fund so examined but the commissioner may in his discretion remit in whole or in part such charges upon showing of extreme financial hardship. For any such examination by the commissioner or a deputy commissioner personally, the charge made shall be only for necessary traveling expenses and other actual expenses. In all other cases the expenses of examination shall also include reimbursement for the compensation paid for the services of persons employed by the commissioner or by his authority to make such examination or appraisal. All charges incurred by the commissioner or in his behalf, including necessary traveling and other actual expenses, as duly audited and paid to the person or persons making the examination or appraisal, shall be presented to the trustees of the employe welfare fund so examined in the form of a copy of the itemized bill therefor as certified and approved by the commissioner or a deputy commissioner. Upon receiving such certified copy such trustees shall pay the amount thereof to the commissioner to be paid by him into the state treasury.

(2) The commissioner shall annually determine filing fees to be paid by every employe welfare fund registered under this chapter. Such fee shall provide for the expenses, not otherwise provided for, of the welfare funds division of the department of insurance, including the general costs of the department of insurance which may appropriately be allocated to such division. The fee so assessed shall be paid with the filing and shall not exceed \$40 per employe welfare fund. In determining the amount of such fee the commissioner shall make allowance for any surplus collected in prior years.

**211.08 Annual statement to commissioner.** The trustees of every employe welfare fund which covers more than 25 persons employed in this state shall file in the office of the commissioner, annually within 5 months after the close of the fiscal year used in maintaining the records of such fund, a statement, to be known as the annual statement of such fund, verified by the oath of its trustee or, if there is more than one trustee, then by the oaths of at least 2 of such trustees, showing its condition and affairs during such fiscal year. Such statement shall be in such form and contain



such substantiation by vouchers and otherwise and such other information as the commissioner from time to time prescribes. The commissioner shall cause to be prepared and furnished to the trustees of every employe welfare fund, required by law to report to him, printed forms of the statements and schedules required by him. For good cause, he may grant reasonable extensions of time for filing under this subsection, not to exceed 90 days.

**History:** 1961 c. 225.

**211.09 Special statements to commissioner.** In addition to any other statements or reports required by this chapter, the commissioner may also address to the trustees of any employe welfare fund or to their officers, agents or employes any inquiry in relation to the transactions or condition of the fund or any matter connected therewith. Every person so addressed shall reply in writing to such inquiry promptly and truthfully, and such reply shall be verified, if required by the commissioner, by such individual or individuals as he shall designate.

**211.10 Reports to employers and employes.** The annual statement and such other statements as the commissioner requires shall be kept on file with the commissioner and at the principal office of the trustees and such statement, or such portion thereof as the commissioner deems appropriate and relevant, shall be made available by the commissioner or by the trustees, or both, for inspection by any employer contributing to such fund, by any labor organization which is a party to an agreement establishing such fund, or by any employe covered by such fund. In addition to such extent that he deems it to be in the public interest, the commissioner may require the trustees to mail such statement, or such portions thereof as the commissioner deems appropriate and relevant, to employes covered by the fund, to contributing employers or to any labor organization which is a party to an agreement establishing such fund, or to any or all such parties.

**211.11 Annual statements by insurance companies, service plans and corporate trustees and agents.** Any insurance company, hospital, surgical or medical service plan providing benefits under an employe welfare fund as defined in this chapter, and any corporate trustee or agent holding or administering all or any part of an employe welfare fund as so defined shall, within 4 months after the end of each policy or fiscal year, furnish to the trustees of the fund a statement of account setting forth such information as the trustees of the fund may need from it in order to comply with the requirements of this chapter.

**211.12 Employer payments to employe welfare funds.** If the trustees of any employe welfare fund have failed to register the fund in accordance with s. 211.03 or are otherwise failing to comply with any of the provisions of this chapter, the commissioner shall so notify the employer and the employer shall make no further payments to the trustees after receipt of such notification unless and until the employer receives further notification from the commissioner stating that the trustees have complied with this chapter.

**History:** 1961 c. 225.

**211.13 Regulation under other laws.** The commissioner may waive examination of any welfare fund which is not located in this state but which is required to register under this chapter, upon being furnished with a certified copy of a report of examination made under the jurisdiction of the proper supervisory official of another state or the federal government which indicates adequate compliance with all of the requirements of this state that would otherwise be determined by an examination directed by the commissioner. Application for such waiver shall be made in writing to the commissioner on such form as he may require and any waiver issued by him shall be in writing and shall be of record in his office. No waiver shall bar the commissioner from investigating any matter not included within the scope of the examination or which is not reported upon to his satisfaction to accomplish the purposes of this chapter in respect to the interests of the employes and employers in this state. The action of the commissioner pursuant to this section shall be subject to judicial review.

**211.14 Compliance, enforcement and penalties.** (1) The trustees of every employe welfare fund required to register under this chapter shall be responsible in a fiduciary capacity for all money, property, or other assets received, managed or disbursed by them, or under their authority, on behalf of such fund. *Trustees shall invest the funds of their trusts and shall manage fund affairs in accordance with provisions contained in the instruments under which they are acting, or in the absence of any such provisions, shall invest in accordance with ch. 320 and shall manage fund affairs in accordance with the judgment and care under the circumstances prevailing, which men of prudence, discretion and intelligence exercise in the management of their own affairs.*

**Note:**  
Matter in *Italics* added.

All payments due to or from every welfare fund subject to [the provisions of] this chapter shall be by check, bank draft, postal money order or other recognized written method of transmitting money or its equivalent.

(2) (a) No trustee, employer or labor organization representing any employes eligible for benefits under an employe welfare plan provided by an employe welfare fund required to register under this chapter, and no officer, agent or employe of any such trustee, employer or labor organization shall receive, directly or indirectly, any payment, commission, loan, service or any other thing of value from any insurance company, insurance agent, insurance broker or any hospital, surgical or medical service plan, in connection with the solicitation, sale, service or administration of a contract providing employe benefits for such fund, or receive any payment, commission, loan, service or any other thing of value from such employe welfare fund, or which is charged against such fund or would otherwise be payable to such fund either directly or indirectly, except that any such person may receive any benefits under an employe welfare plan to which he is otherwise entitled, and any such trustee, or his officer, agent or employe, may receive from such employe welfare fund reasonable compensation for necessary services and expenses rendered or incurred by him in connection with his official duties as such; provided that nothing in this section shall affect the payment of any dividend or rate credit or other adjustment due under the terms of any insurance or annuity contract to the policyholder or contract holder.

(b) No trustee shall invest any employe welfare fund moneys in any security, obligation, or other property from which the individual trustees of the fund, the employer company contributing to the fund or any of its officers or directors, any corporation controlled by the employer company or by its officers or directors through ownership of more than 50% of the outstanding stock, or the labor organization representing employes covered by the fund or any of its affiliates, or officers or employes of either, receive any part of the moneys invested unless the purchase price of such security, obligation or other property is reasonable, and unless an investment in any obligation is adequately secured. Adequate security shall be deemed to have been given if such obligation is registered on a national securities exchange or pursuant to the securities and exchange commission regulations or is of senior or substantially equal rank to a security registered on a national securities exchange or pursuant to the securities and exchange commission regulations. Nothing herein shall foreclose other means of providing adequate security.

(3) No political contributions shall be made directly or indirectly by or from any employe welfare fund.

(4) (a) Any person who wilfully violates or fails to comply with any provision of this chapter or the rules [or regulations] promulgated thereunder or who *knowingly*, makes a false statement [~~or~~], a false representation of a material fact, [~~knowing it to be false,~~] or who [~~knowingly~~] fails to disclose a material fact in any registration, examination, statement or report required under this chapter or the rules [or regulations] promulgated thereunder, [~~shall~~] *may* be fined not more than \$5,000, or imprisoned not more than 5 years, or both.

(b) Any person who embezzles, steals, or unlawfully and wilfully abstracts or converts to his own use or to the use of another, any of the moneys, funds, securities, premiums, credits, property, or other assets of any employe welfare fund, or of any fund connected therewith, shall be fined not more than \$10,000 or imprisoned not more than 5 years, or both.

(5) In any case where, after notice and a hearing, the commissioner finds that any employe welfare fund has been depleted by reason of any wrongful or negligent act or omission of a trustee or of any other person, he may transmit a copy of his findings to the attorney general, who may bring an action in the name of the people of the state, or intervene in an action brought by or on behalf of an employe, for the recovery of such fund for the benefit of the employes and such other persons as may have an interest in the fund.

(6) If any trustee, agent or employe of an employe welfare fund fails or refuses to register such fund or to file the annual statement or any special statement required under this chapter, within the time prescribed for such filing, after 20 days' notice from the commissioner he shall be subject, at the discretion of the commissioner, to a forfeiture of \$5 per day for each and every day of default, but not to exceed \$500 for any default, and the commissioner may maintain an action in the name of the state to recover such

Note:

Matter in [brackets] is deleted.  
Matter in *Italics* added.

forfeiture, and the same shall be paid into the state treasury. A forfeiture imposed under this section upon any trustee shall not be recovered from the fund.

**History:** 1961 c. 225.

**Cross Reference:** See 103.86 for provision for penalty for employers who default in payments to a welfare fund.

**211.15 Injunctions.** (1) The commissioner may maintain and prosecute an action against any trustee or any other person or persons subject to any provisions of this chapter, for the purpose of obtaining an injunction restraining such persons from doing any acts in violation of this chapter. If the court finds that a defendant is threatening or is likely to do any act in violation of this chapter, and that such violation will cause irreparable injury to the interests of the people of this state or the beneficiaries of the employe welfare fund involved or any employer contributing to such fund, the court may grant an injunction restraining such violation. The court may, on motion and affidavits, grant a preliminary injunction ex parte and an interlocutory injunction, upon such terms as may be just; but the commissioner shall not be required to give security before the issuance of any such injunction.

(2) In any case where an employer doing business in the state continues to make payments to trustees of an employe welfare fund after receipt of notification from the commissioner pursuant to s. 211.12 that the trustees have failed to register the fund or are otherwise failing to comply with the provisions of this chapter, the commissioner shall forthwith apply for an injunction, as provided in sub. (1), to restrain the employer from making any further payments to the trustee or trustees pending further order of the court; and if the court finds that the trustees have failed to register the fund or are otherwise failing to comply with any of the provisions of this chapter, the court may permanently enjoin such payments and make such further orders as may be necessary to protect the interests of the employes or the employers in this state with respect to any further payments to the fund from the employer.

(3) Either the commissioner or the employer or the trustees or any trustee may apply to the court at any time to have an injunction issued under this chapter vacated.

**211.16 Advisory council.** (1) The commissioner shall appoint an advisory council on employe welfare plans which shall consist of 7 members, 2 to be representatives of management, 2 to be representatives of employes, and 3 to be representatives of the general public from the fields of banking, economics and insurance.

(2) It shall be the duty of the council to advise the commissioner with respect to the carrying out of his functions under this chapter, to review the administration of this chapter and to make such reports and recommendations to the commissioner with respect to amendments thereto as it deems necessary in the public interest. The council shall meet at least once each year and at such other times as it deems necessary or the commissioner requests. Members of the council shall receive no salary, or compensation for service on the council but shall be entitled to reimbursement for necessary expenses.

**211.17 Construction.** (1) Nothing in this chapter shall be construed to relieve the trustees of any employe welfare fund from compliance with any other provision of this chapter or any other applicable laws of this state.

(2) In order to carry out the objectives of this chapter to protect the interests of the employes or the employers in this state from fraud and mismanagement of employe welfare funds and to assure the faithful discharge of the responsibilities of the trustees and fiduciaries of such funds, the provisions of this chapter are to be liberally construed.

STATE OF WISCONSIN  
OFFICE OF THE COMMISSIONER  
OF INSURANCE  
ROBERT D. HAASE, COMMISSIONER  
4802 SHEBOYGAN AVENUE  
MADISON 53702

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To Study Reorganization and Public Information Matters  
(A3) Subcom. Report

A Meeting of the Subcommittee To Study Reorganization and Public Information Matters was held on June 17, 1968, at 11:00 A.M. in the Hilton Hotel, Portland, Oregon.

The entire membership of the Subcommittee was present or represented.

The Chairman read the Report of the Subcommittee Meeting held in New York on February 8, 1968, (ref: 1968 Proc. Vol. II pages 383-384) and advised the Subcommittee Members that this Report had been accepted and approved by the Executive Committee. Then, the Chairman presented to the Subcommittee, Mr. Robert E. Dineen, who was retained previously by the Executive Committee, as a Consultant to the NAIC as of Sept. 1, 1968. Mr. Dineen read a statement on policy, as to how he believed the new Central Office should operate. This statement is attached hereto, and made a part of this report.

Hon. Charles R. Howell, Commissioner of Insurance of New Jersey, offered a resolution recommending to the Executive Committee how the new Central Office should be operated. The resolution was seconded and unanimously adopted by the Subcommittee, and is attached hereto and made a part of this report.

There being no further business, the Meeting was adjourned.

Hon. T. Nelson Parker, Chm., Va.; Hon. Richard E. Stewart, V.Chm., N. Y.; Hon. Richard S. L. Roddis, Calif.; Hon. J. Richard Barnes, Colo.; Hon. James L. Bentley, Ga.; Hon. C. Eugene Farnam, Mass.; Hon. Walter D. Davis, Miss.; Hon. Donald Knowlton, N. H.; Hon. Charles R. Howell, N. J.; Hon. Lee I. Kueckelhan, Wash.

Statement of Policy

The Research Function of the Central Staff of the NAIC

Administrative Service Office

One of the primary functions of the central staff of the new Administrative Service Office will be research and the dissemination of the results of research (whether conducted by the staff or by others) to the commissioners and their departmental staffs in the form of oral and/or written reports. This as well as other functions will be conducted under the general direction of the NAIC Executive Committee. Because of the initial size of the central staff, the number of projects which can be undertaken will have to be somewhat limited.

The central staff will marshal facts, analyze issues, point up various available alternatives, and prepare reports. It will not assume a policy-making role. The ultimate decisions as to what should be done with the research rests with the commissioners. The research will not be binding on either individual commissioners in particular or the NAIC in general. Furthermore, a published study prepared by the staff will contain a disclaimer to the effect that it does not necessarily represent the opinion of the NAIC.

This approach is akin to that used by Congressional committees, federal agencies, state legislatures, and business. Congressional committees have their own staffs

to pull together background material and present alternatives. However, no one maintains that the individual members of Congressional committees are bound to the findings or the suggestions of the committee staffs. Hearings are held to air the views of others. Similarly, the staff of the Securities and Exchange Commission can at most only recommend alternatives to the Commission. The staff itself cannot determine policy except to the extent that its proposals are persuasive.

Where appropriate, industry briefs and the views of other interested parties will be solicited either concurrently with or supplemental to the study of the central staff (perhaps in the form of a rebuttal). Such studies or briefs may be submitted to the NAIC either separately or together as a package. At no time is it contemplated that an NAIC staff report should foreclose the discussion of the topic under consideration. It is quite important that persons holding a contrary view to that of the central staff be able to present their ideas with the knowledge that the NAIC is not only uncommitted but actually seeks fresh viewpoints to balance against those of the staff. Through this technique it is believed that the NAIC and the individual commissioners will be the beneficiaries of extensive and objective research in depth which will afford an opportunity to make informed policy decisions based on various documented alternatives.

#### A RESOLUTION (Second revision)

WHEREAS, the National Association of Insurance Commissioners (NAIC) desires to create a staff, as part of an enlarged Administrative Service Office, to perform research and related functions, and

WHEREAS, the Executive Committee began implementing this reorganization program in its March 11, 1968 resolution adopted at the meeting in Jackson, Wyoming, and

WHEREAS, further developments make it desirable to refine and update that resolution,

#### NOW THEREFORE BE IT RESOLVED,

(1) That this resolution be in lieu of the March 11, 1968 resolution of the Executive Committee pertaining to the reorganization of the NAIC,

(2) That the New Administrative Service Office be established on or about July 1, 1968,

(3) That the office be located temporarily in the City of Milwaukee until such time as the Executive Committee of the Association determines the need to move it elsewhere,

(4) That the activities conducted in the Des Plaines office be merged into the new Milwaukee office operations on or before July 31, 1968,

(5) That the office equipment in the Des Plaines office be transferred to the Milwaukee Office on or before July 31, 1968,

(6) That the NAIC give timely notice for termination of the month-to-month lease for the Des Plaines office as of July 31, 1968,

(7) That the services of Jon S. Hanson be obtained as Director of Research at an initial salary of \$16,000 per year, increased to \$18,000 per year commencing June 1, 1969, if his services are satisfactory to the Executive Committee, and that the fringe benefits be accorded as in the other NAIC offices,

(8) That the Director of Research be authorized to employ administrative, secretarial and stenographic assistance and to pay salaries and fringe benefits within the limits provided for in the attached appropriations,

(9) That subject to the approval and necessary appropriations by the Executive Committee, the Director of Research is authorized to retain consultants for research projects that can be performed most effectively and economically on a retainer basis,

(10) That the Director of Research initially concentrate on the research, briefing, and informational services functions,

(11) That the Director of Research is authorized to develop a working relationship with the NAIC Washington counsel,

(12) That the Director of Research be authorized to open checking and savings accounts in the name of and on behalf of the NAIC,

(13) That the Director of Research be authorized to receive income and to sign on behalf of the Association, checks, receipts, or orders for the payment or withdrawal of funds deposited in checking or savings accounts with respect to the payment of bills, including salaries and moving expenses, related to the day-to-day operations and the equipping of the new expanded Administrative Service Office, subject to the appropriations set forth therein,

(14) That the Director of Research be authorized on behalf of the NAIC to negotiate for and lease office space for the new Administrative Service Office,

(15) That the Director of Research must provide an appropriate bond at NAIC expense,

(16) That on July 1, 1968, the existing checking and savings accounts used in connection with the Des Plaines office operations be closed and the balances transferred to the new Administrative Service Office, that the Wisconsin Department of Insurance be requested to conduct a special closing audit, that the remaining expenses of the Des Plaines office be paid by the new Administrative Service Office, and that any income received by the Des Plaines office thereafter be forwarded to the Administrative Service Office,

(17) That the services of Robert E. Dineen be retained as Consultant (with no retirement or fringe benefits) to assist the establishment and operation of the new Administrative Service Office at a fee of \$12,000 per year, effective September 1, 1968.

(18) That the attached appropriations for the new Administrative Service Office be approved.

(19) That, as of July 31, 1968, Mr. Tollack be retired (receiving the benefits under the NAIC Retirement Plan), and the services of Mrs. Tollack be terminated.

(20) That, subject to the approval of the President (Chairman of the Executive Committee), the Director of Research is authorized, in his discretion, to retain on a temporary basis Mr. Tollack or some other qualified person, with such additional temporary help as is necessary to assist in the transition, and that the appropriations be adjusted accordingly.

#### AMENDED RESOLUTION (Third revision)

of the (A3) Subcommittee

To Study Reorganization and Public Information Matters

June 20, 1968

NOW THEREFORE BE IT RESOLVED,

1. That this resolution be in lieu of the March 11, 1968 resolution of the Executive Committee pertaining to the reorganization of the NAIC,
2. That the New Administrative Service Office be established on or about July 1, 1968,
3. That the office be located temporarily in the City of Milwaukee until such time as the Executive Committee of the Association determines the need to move it elsewhere,
4. That the activities conducted in the Des Plaines office be merged into the new Milwaukee office operations on or before July 31, 1968,
5. That the office equipment in the Des Plaines office be transferred to the Milwaukee office on or before July 31, 1968,
6. That the NAIC give timely notice for termination of the month-to-month lease for the Des Plaines office as of July 31, 1968,
7. That the services of Jon S. Hanson be obtained as Acting Executive Secretary and Director of Research at an initial salary of \$16,000 per year, increased to \$18,000 per year commencing June 1, 1969, if his services are satisfactory to the Executive Committee, and that the fringe benefits be accorded as in the other NAIC offices,
8. That the Acting Executive Secretary and Director of Research be authorized to employ administrative, secretarial and stenographic assistance and to pay salaries and fringe benefits within the limits provided for in the attached budget,

9. That subject to the approval and necessary budget by the Executive Committee, the Acting Executive Secretary and Director of Research is authorized to retain consultants for research projects that can be performed most effectively and economically on a retainer basis,
10. That the Acting Executive Secretary and Director of Research initially concentrate on the research, briefing, and informational services functions,
11. That the Acting Executive Secretary and Director of Research is authorized to develop a working relationship with the NAIC Washington counsel,
12. That the Acting Executive Secretary and Director of Research be authorized to open checking and savings accounts in the name of and on behalf of the NAIC,
13. That the Acting Executive Secretary and Director of Research under the direction of the Secretary-Treasurer of the Association, be authorized to receive income and to sign on behalf of the Association, checks, receipts, or orders for the payment or withdrawal of funds deposited in checking or savings accounts with respect to the payment of bills, including salaries and moving expenses, related to the day-to-day operations and the equipping of the new expanded Administrative Service Office, subject to the budget set forth therein,
14. That the Acting Executive Secretary and Director of Research be authorized on behalf of the NAIC to negotiate for and lease office space for the new Administrative Service Office,
15. That the Acting Executive Secretary and Director of Research must provide an appropriate bond at NAIC expense,
16. That on July 1, 1968, the existing checking and savings accounts used in connection with the Des Plaines office operations be closed and the balances transferred to the new Administrative Service Office, that the Wisconsin Department of Insurance be requested to conduct a special closing audit, that the remaining expenses of the Des Plaines office be paid by the new Administrative Service Office, and that any income received by the Des Plaines office thereafter be forwarded to the Administrative Service Office,
17. That the services of Robert E. Dineen be retained as Consultant (with no retirement or fringe benefits) to assist the establishment and operation of the new Administrative Service Office at a fee of \$12,000 per year, effective September 1, 1968.
18. That the attached budget for the new Administrative Service Office be approved.
19. That, as of July 31, 1968, Mr. Tollack be retired and thereby entitled to receive the benefits under the NAIC Retirement Plan,
20. That, the President of the NAIC, in his discretion and under such terms as he may prescribe, be authorized to expend up to \$11,000 in severance pay for the retiring Executive Secretary, Mr. Tollack,
21. That, subject to the approval of the President (Chairman of the Executive Committee), the Acting Executive Secretary and Director of Research is authorized, in his discretion, to retain on a temporary basis Mr. Tollack or some other qualified person, with such additional temporary help as is necessary to assist in the transition, and that the budget be adjusted accordingly,
22. That the current assessment formula (known as Plan I) to finance the enlarged Administrative Service Office be revised to provide that state contributions be assessed in direct proportion to premium volume to meet the budget except that no state will be assessed an amount less than \$1,000 per year.

OPERATIONAL BUDGET FOR THE NEW NAIC ADMINISTRATIVE  
SERVICE OFFICE

July 1968 to June 1969

Salaries	\$ 27,000
Benefits	6,700
Consultant Fee	12,000
Rent	4,800
Telephone	2,000
Postage	1,200
Travel	8,000
Equipping Office	3,500
Library & Source Materials	2,800
Miscellaneous	500
Remodeling Cost	<u>500</u>
Cost of New Office	\$ 69,000
Cost of Des Plaines Functions Assumed by Milwaukee (see detailed breakdown below)	<u>+29,100</u>
Total Cost of Administrative Services and Assumed Des Plaines work	<u>\$ 98,100</u>
Cost of Washington Counsel, accounted through the Administrative Office	<u>\$ 18,000</u>
Savings on Assumption of Work from Des Plaines	
Des Plaines 1967-68 Expense	\$ 63,700
Less Work Assumed by Milwaukee	<u>-39,100</u>
Savings	\$ 24,600

COST OF DES PLAINES FUNCTIONS ASSUMED BY MILWAUKEE

Salaries	\$ 9,000
Benefits	2,000
Rent	2,100
Printing	13,000
Postage	2,500
Moving Expense	500
Costs Related to Examination Function	<u>10,000</u>
	\$ 39,100



AMENDED BUDGET  
(Fiscal year ending May 31, 1969)

<b>I. Operational Costs</b>		
Salaries	\$ 27,000	
Benefits	6,700	
Consultant Fee	12,000	
Rent	4,800	
Telephone	2,000	
Postage	1,200	
Travel	8,000	
Equipping Office	3,500	
Library and Source Materials	2,800	
Miscellaneous	500	
Remodeling Cost	<u>500</u>	
Cost of New Office	\$ 69,000	
Cost of Des Plaines Functions Assumed by Milwaukee (see below)	<u>+38,600</u>	
Operational Cost		\$107,600
<b>II. Transition Costs</b>		
Moving Expense	500	
Severance Allowance	11,000	
Miscellaneous	<u>1,000</u>	
Transition Cost		12,500
<b>III. Contingency Fund</b>		
Reserve	25,000	
Development of Professional Staff	<u>20,000</u>	
Contingency Fund		45,000
<b>IV. Washington Counsel</b>		
		<u>18,000</u>
Total		<u>\$183,100</u>

COST OF DES PLAINES FUNCTION ASSUMED BY MILWAUKEE

Salaries	\$ 9,000
Benefits	2,000
Rent	2,100
Printing	13,000
Postage	2,500
Costs Related to the Examination Function	<u>10,000</u>
	<u>\$38,600</u>

## Liaison with State Agencies (A4) Subcom. Report

(Mtg. 3)

The (A4) Subcommittee, Liaison with State Agencies, met in Executive Session at 3:30 P.M. on June 16, 1968, in the Portland Hilton Hotel.

The Chairman reported to the Subcommittee on his contacts with the Insurance Laws Committee of the National Association of Attorneys General, including a meeting with that Committee in Baltimore on April 22, 1968. He outlined the concern expressed by the Attorneys General with respect to certain aspects of state regulation of insurance.

The Chairman also reported that he had been contacted by a representative of the National Governors Conference with respect to a proposed resolution of that Conference calling for the formation of an ad hoc committee to draft a model state auto insurance law.

A general discussion ensued concerning the relationship between the NAIC, through the (A4) Subcommittee, the Attorneys General and the Governors.

It was the sense of the meeting that the (A4) Subcommittee should express to the Insurance Laws Committee of the National Association of Attorneys General our appreciation for their desire to be of assistance to the Insurance Commissioners in discharging the Commissioners' responsibilities to regulate insurance and to call on that Committee to join with the Insurance Commissioners in a vigorous defense of the principle of state regulation in this field.

The (A4) Subcommittee will also inform the Insurance Laws Committee of the National Association of Attorneys General of our continuing interest in attending and participating in any meetings of that Committee which may be held in the future. The members of the Subcommittee felt that the recommendation of President Bentley that we keep open the lines of communication with the National Governors Conference was well taken, and it will be implemented.

Hon. David O. Maxwell, Chm., Pa.; Hon. Benjamin C. Neff, Jr., V.Chm., Neb.; Hon. Dudley A. Guglielmo, La.; Hon. Thomas C. Hunt, Minn.; Hon. Donald Knowlton, N. H.; Hon. James R. Faulstich, Ore.

State of Wisconsin  
Office of the Commissioner of Insurance

Robert D. Haase, Commissioner  
4802 Sheboygan Avenue  
Madison 53702

Honorable Ned Price  
State Board of Insurance  
Chairman, NAIC  
Executive Committee  
Austin, Texas 78701

Re: Audit Report of Non-admitted Insurers Information Office for  
Fiscal Year June 1, 1967, through May 31, 1968

This is to certify that we have examined the records of the Honorable Donald Knowlton, Chairman of the Unauthorized Insurers Subcommittee of the Property Casualty and Surety Insurance Committee of NAIC, as submitted for examination by Joseph A. Humphreys, Executive Director, 60 Wall Street, New York, New York.

This is to further certify that all income received between June 1, 1967, and May 31, 1968, inclusive, shown in the cash records was deposited in the Bankers Trust Company, New York Account Number 40-811-094, and disbursements were supported by vouchers or invoices.

This is to further certify the cash balance as disclosed by the records submitted by Joseph A. Humphreys as shown in Exhibit B attached hereto was \$743.47 as of May 31, 1968, and that such cash balance was reconciled to the certified bank statement received direct from the bank by your examiner.

Respectfully submitted,

Robert D. Haase  
Commissioner of Insurance  
State of Wisconsin

By: Martin F. Raynoha  
Chief, Examining Division

## EXHIBIT B.

## NON-ADMITTED INSURERS INFORMATION OFFICE

## Cash Reconciliation

Cash Balance June 1, 1967		\$ 365.47
Receipts		
Subscriptions	\$ 7,425.00	
Additional Statements	153.00	
Listings	<u>2,850.00</u>	
Total Receipts		10,428.00
Total Receipts and Balance		<u>\$10,793.47</u>
Checks Issued to NAIC in		
Reimbursement for Expenses Paid	\$10,000.00	
Check, Issued as Refund on Overpayment for Statement	<u>50.00</u>	10,050.00
Cash Balance May 31, 1968		<u>\$ 743.47</u>

STATEMENT OF ACCOUNT  
OF THE NON-ADMITTED INSURERS  
INFORMATION OFFICE  
WITH NAIC

Balance Due to NAIC June 1, 1967	\$ 8,005.37*
Expense Disbursements by NAIC for NAIIO	<u>16,644.34</u>
	\$24,649.71
Payments by NAIIO to NAIC	<u>10,000.00*</u>
Balance Due to NAIC May 31, 1968	<u>\$14,649.71</u>

CLASSIFICATION OF EXPENSE DISBURSEMENTS BY NAIC FOR NAIIO  
JUNE 1, 1967 - MAY 31, 1968

Compensation -- Executive Director	\$10,800.00
Expenses -- Executive Director	1,557.04
Compensation -- Clerical & Other	1,949.05
Expenses -- Clerical & Other	169.19
Telephone and Telegraph	744.20
Printing	440.50
Duplicator & Supplies therefor	339.79
Financial Service	390.16
Postage	128.41
Legal and Copyright	126.00
TOTAL	<u>\$16,644.34</u>

\*This treats a check issued to NAIC May 25, 1967, for \$3,000 as paid during May, 1967. However, it should be noted that such check was in transit at May 31, 1967 and not received by the Executive Secretary until June 2, 1967. Therefore, the records of the Executive Secretary reflect such \$3,000 item as unpaid May 31, 1967, resulting in a consequent increase of \$3,000 in the corresponding income item for 1967-1968 in the report of the Executive Secretary's office.

State of Wisconsin  
Office of the Commissioner of Insurance

Warren P. Knowles  
Governor

Robert D. Haase  
Commissioner

June 10, 1968

Honorable Ned Price  
Commissioner of Insurance  
State Board of Insurance  
Chairman, NAIC Executive Committee  
Austin, Texas 78701

Dear Sir:

Audit Report of Executive Secretary's Office  
For Fiscal Year June 1, 1967, through May 31, 1968

This is to certify that we have made an audit of the records of the Honorable Ralph F. Apodaca, Secretary-Treasurer of the National Association of Insurance Commissioners, in the office of the Executive Secretary, Hugh L. Tollack, located at 730 Lee Street, Des Plaines, Illinois.

This is to further certify that all receipts in the period June 1, 1967, to May 31, 1968, inclusive, shown in the cash records were deposited in the bank and that all disbursements were supported by vouchers or invoices.

This is to further certify the cash balance as disclosed by the records submitted by the Secretary-Treasurer and as shown in the financial statement, attached hereto as Exhibit A, was \$120,966.18 as of May 31, 1968, and was reconciled to the checkbook records and to the certified bank statement received direct from the bank by your examiner.

Respectfully submitted,

Robert D. Haase  
Commissioner of Insurance  
State of Wisconsin

By: Martin F. Raynoha  
Chief, Examining Division

MFR:IMK  
Enc.

## EXHIBIT A

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS  
FINANCIAL STATEMENT — EXECUTIVE SECRETARY'S OFFICE

For The Fiscal Period June 1, 1967

Through May 31, 1968

Cash Balance June 1, 1967		\$ 44,493.98
<b>Income</b>		
NAIC Proceedings	\$14,011.99	
Registration Fees	10,140.00	
Printed Matter	1,076.31	
State Payments		
6/1/67 - 5/31/68	136,215.00	
6/1/66 - 5/31/67	4,500.00	
Non-Admitted Insurers Information Office	13,000.00	
Valuation of Securities Office (OASI Taxes)	7,284.59	
Interest Received - Savings Accounts	2,628.47	
Postage Recovery	2.20	
Total Income	188,808.56	
Total Income and Beginning Cash		\$233,302.54
<b>Disbursements</b>		
Salaries (less OASI)	\$28,848.79	
OASI—New York (Val. of Sec.)	7,234.59	
OASI—Des Plaines	1,215.14	
Fringe Benefits	6,312.27	
Rent and Services	4,214.88	
Telephone and Telegraph	1,245.79	
Proceedings	7,586.57*	
Transcripts and Handbooks	2,046.44	
Travel and Expense	2,067.89	
Office Supplies	330.05	
Furniture and Equipment	57.85	
Postage and Meter	1,593.60	
Misc. Office Maintenance	1,489.82	
Non-Admitted Insurers Office	16,644.34	
Legal Services	12,297.98	
Special Account (W & F)	17,615.36	
Decrease in Unallocated Funds	1,535.00	
Total Disbursements	112,336.36	
Cash Balance May 31, 1968		\$120,966.18

\*The payment of a \$5,263.52 printing bill dated May 13, 1968, for Proceedings is being deferred until payments for the individual volumes have been received from the standing order accounts in sufficient amount to pay the bill.

Cash Balance May 31, 1968

The First National Bank of Chicago Checking A/C		\$ 1,388.86
The First National Bank of Chicago Savings		
A/C 1-967-546	102,297.71*	
The First National Bank of Chicago Savings		
A/C 1-953-043	17,279.61	
Total	\$120,966.18	

\*Includes \$300 Nevada and \$1,605 Wyoming general fund advance state payments and \$3,055 in registration fees to be included in the allocated income of the fiscal year beginning June 1, 1968, and \$2,000 in transit from the checking account to that savings account.

**Executive Secretary's Report****May 31, 1967 to June 1, 1968**

The following information regarding the activities of the Executive Secretary's Office during the last fiscal year (May 31, 1967 to June 1, 1968) are submitted for your consideration.

1. Cost of postage has been over \$1,300.00
2. Approximately 215 Association Examination Calls were distributed to the Zone Chairman. The usual tabulation for those distributed since December 1, 1967 is a part of the Examination's Committee Report.
3. As usual, a financial statement with a tabulation of payments made by NAIC members is attached.

Respectively submitted,

Hugh L. Tollack

## NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

## Financial Statement — Central Office

as of May 31, 1968

<u>OPERATING ACCOUNT</u>	<u>May, 1968</u>	<u>Accumulated 5/31/67-5/31/68</u>
<u>INCOME</u>		
Audited Balance		\$ 3,150.13
Checking Acct. Balance 4/30/68	\$ 1,715.53	
A. State Payments	7,830.00	136,215.00
B. Proceedings		
1967 VOL. I		\$ 5,654.20
1967 VOL. II	\$ 40.00	6,177.89
Other	77.00     117.00	2,179.90     14,011.99
C. Printed Matter	145.00	1,076.31
D. Registration Fees	*10,140.00	*10,140.00
E. Misc. OASI — N. Y.		7,234.59
Non-Admitted repayment		13,000.00
Other		2.20     20,236.79
F. Special Account		
G. Savings Accts. Withdrawal		
H. State Payments (5/31/66-6/1/67)		4,500.00
I. Interest	2,628.47	2,628.47
	<u>\$22,576.00</u>	<u>\$191,958.69</u>
Less amount in Savings Account	<u>-10,140.00</u>	<u>-10,140.00</u>
	<u>\$12,436.00</u>	<u>\$181,818.69</u>

\*Note: Amount to be withdrawn from Savings Acct. at close of this calendar quarter.

<u>DISBURSEMENTS</u>			
1. Salaries (Net)	\$2,054.86		\$24,473.59
W/H Inc.	364.60     2,419.46		4,375.20     \$ 28,848.79
OASI	38.87		651.21
Salaries (Gross)	<u>\$2,458.33</u>		<u>\$29,500.00</u>
2. NAIC			
OASI — N. Y.			7,234.59
OASI — Des Plaines			1,215.14
Fringe Benefits	\$ 71.31     71.31		6,312.27     14,762.00
3. Rent & Services		319.00	4,214.88
4. Tel. & Tel.		84.33	1,245.79
5. Proceedings		244.81	7,586.57
Transcript			2,046.44
6. Travel & Expense		420.00	2,067.89
7. Office Supplies			330.05
8. Furn. & Equip.			57.85
9. Postage & Meter		1,500.00	1,593.60
10. Misc. Prtg., Maintenance, Bond		244.55	1,439.82
11. Petty Cash			
12. Special Account			17,615.36
13. Non-Admitted Office		1,115.21	16,644.34
14. To Savings Accts.		2,000.00	67,000.00
15. To Legal Services			
Retainer Fees			9,000.00
Expenses			3,297.98     12,297.98
	<u>\$ 8,418.67</u>		<u>\$177,801.36</u>
Bank Balance 5/31/68 (reconciled)		1,388.86	1,388.86
Interest		2,628.47	2,628.47
	<u>\$12,436.00</u>		<u>\$181,818.69</u>



PAYMENTS BY NAIC MEMBERS

Fiscal year 5/31/67 - 6/1/68

	GENERAL FUND	1967 PROC. VOL. II p. 299 PLAN I
Alabama	\$ 3,000.00	\$ 4,732.00
Alaska	200.00	3,181.00
Arizona	1,200.00	4,092.00
Arkansas	4,021.00	4,021.00
California	3,000.00	18,862.00
*Colorado	*5,000.00	4,293.00
Connecticut	1,350.00	5,385.00
Delaware	200.00	3,318.00
Dist. of Columbia	50.00	3,633.00
Florida	5,000.00	7,255.00
Georgia	5,861.00	5,861.00
Guam	100.00	3,011.00
Hawaii	500.00	3,439.00
Idaho		3,422.00
Illinois	2,000.00	12,760.00
Indiana	6,771.00	6,771.00
Iowa	5,108.00	5,108.00
Kansas	500.00	4,631.00
Kentucky	500.00	4,712.00
Louisiana	2,250.00	5,287.00
Maine	225.00	3,278.00
Maryland	5,730.00	5,730.00
Massachusetts	1,000.00	7,556.00
Michigan	1,000.00	10,041.00
Minnesota	1,000.00	5,541.00
Mississippi	150.00	4,051.00
Missouri	6,187.00	6,187.00
Montana	1,150.00	3,450.00
Nebraska	500.00	4,400.00
+ Nevada	500.00	3,304.00
New Hampshire	200.00	3,543.00
New Jersey	5,000.00	9,178.00
New Mexico	3,618.00	3,618.00
New York	6,000.00	23,614.00
North Carolina	400.00	5,567.00
North Dakota	3,340.00	3,340.00
Ohio	10,909.00	10,909.00
Oklahoma	500.00	4,649.00
Oregon	575.00	4,382.00
Pennsylvania	3,500.00	12,065.00
Puerto Rico	3,330.00	3,330.00
Rhode Island	200.00	3,757.00
South Carolina	400.00	4,432.00
South Dakota	3,424.00	3,424.00
Tennessee	750.00	5,681.00
Texas	12,627.00	12,627.00
Utah	250.00	3,580.00
Vermont	200.00	3,246.00
Virgin Islands	100.00	3,012.00
Virginia	5,644.00	5,644.00
Washington	5,176.00	5,176.00
West Virginia	300.00	3,881.00
Wisconsin	2,500.00	6,211.00
+ Wyoming	3,219.00	3,219.00
	<u>\$136,215.00</u>	<u>\$315,397.00</u>

\*Colorado — Includes \$707.00 for Special Funds.

+Nevada — \$300.00; Wyoming — \$1,605.00 for 1968-69.

## BLANKS (A5) COMMITTEE

## AGENDA - MTG #39

WEDNESDAY P.M. JUNE 19, 1968

1:30-2:45 BALLROOM B

+JOINT MEETING

## Reference

1968 Proc. VOL. I p. 61

1. BLANKS (A5) COMMITTEE Report  
(Meeting March 25-27, 1968 — New York, N. Y.)
2. +Fire, Casualty and Reciprocal Blank (A5a) Subcom. Report (Mtg. +40)  
Hon. Richard E. Stewart by William C. Gould, Chm., N. Y.  
Hon. Clay Cotten by E. J. Voorhis, Jr., V.Chm., Texas
3. To determine what steps should be taken to permit the separation of property coverage premiums from the homeowners and other comprehensive policies, to enable the insurance companies to report separately this coverage premium so as to provide for a proper assessment by state in the event a National Insurance Development Corporation is established. (Vermont)
4. Any other matter submitted for consideration.

## BLANKS (A5) COMMITTEE Report

(Mtg. 39)

The Blanks (A5) Committee met in Ballroom B of the Portland Hilton Hotel in Portland, Oregon at 1:30 p.m., June 19, 1968. The Chairman called the roll, and a quorum was present.

The Committee voted to recommend to the Executive Committee that certain changes be made in the Fire and Casualty Blank, Life and Accident and Health Blank, Separate Account Business Blank, Fraternal Blank, Title Blank, and Hospital, Medical and Dental Service or Indemnity Corporations Blanks, as set forth in detail in revised Report attached hereto, and made a part of this Report.

The Committee further voted to adopt and recommend to the Executive Committee the Report of the Special Meeting of the Fire, Casualty and Reciprocal Blank Subcommittee, which recommended that certain changes in Schedule "P" be incorporated in the 1969 Fire and Casualty Blank. The Report of the Subcommittee is attached hereto.

The Committee also voted to adopt the Report of Subcommittee to study Terminology Proposals, which is attached hereto.

The Committee also discussed the question: "What steps should be taken to permit the separation of property coverage premiums from the home-

owners and other comprehensive policies, to enable the insurance companies to report separately this coverage premium so as to provide for a proper assessment by state in the event a National Insurance Development Corporation is established?"

No action was taken.

There being no further business, the meeting was adjourned.

Hon. James H. Hunt, Chm., Vt.; Hon. Richard S. L. Roddis, V.Chm., Calif.; Hon. Jerry P. Shea, Ariz.; Hon. Broward Williams, Fla.; Hon. James L. Bentley, Ga.; Hon. Joseph G. Wood, Ind.; Hon. Frank Sullivan, Kans.; Hon. Robert D. Preston, Ky.; Hon. David J. Dykhouse, Mich.; Hon. Robt. D. Scharz, Mo.; Hon. Benjamin C. Neff, Jr., Nebr.; Hon. Charles R. Howell, N. J. by W. Harold Bittel; Hon. Richard E. Stewart, N. Y.; Hon. David O. Maxwell, Pa.; Hon. David M. Pack, Tenn.; Hon. Clay Cotten, Texas; Hon. T. Nelson Parker, Va.; Hon. Lee I. Kueckelhan, Wash.; Hon. Robert D. Haase, Wis.

To the Honorable Ned Price, Chairman, Executive Committee, National Association of Insurance Commissioners:

Sir: The Committee on Blanks herewith submits, for adoption by the Executive Committee, the following revised report on the proceedings of its meetings held at the Hotel Americana, New York City, March 25-27, 1968, inclusive:

#### FIRE AND CASUALTY BLANK

1. Page 3, Line 28  
 Capitalize the word "Total" appearing on Page 3, Line 28, to make it uniform with the word "TOTAL" appearing on Page 2, Line 22.  
 Reason: Editorial consistency.
2. Page 13, General Interrogatory 24  
 Change to read as follows:  
 "24. Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation or deed of settlement of the company?  
 Answer ----- If so, when? -----  
 If not previously filed, furnish herewith a certified copy of the instrument as amended."  
 Reason: To provide an identifying date for checking submissions.
3. Page 14, State Business Page  
 Add a footnote below the Credit Accident and Health Insurance Exhibit, as follows:  
 "\*\*\* The figures shown in these columns should be consistent with the corresponding figures in the Credit Life and Accident and Health Exhibit."  
 Double asterisks (\*\*) should be placed in the columns headed "Direct Premiums Earned" and "Direct Losses Incurred" to which this footnote will apply.  
 Reason: To indicate the necessity of consistent reporting.
4. Page 25, Note relating to Reinsurance Assumed  
 Add the following note relating to Reinsurance Assumed below those now appearing at the bottom of Page 25:

“The figures reported here for Premiums Earned and Losses Incurred in current year should contain all reinsurance assumed and should reconcile Page 6, Part 2, Column 4 and Page 8, Column 9 with Page 39, Columns 4 and 5; Page 7, Part 2C, Column 3; Page 8, Column 3; Schedule F, Part 1A, Section 1, Columns 1, 2 and 4; and the same data in Schedule F of the previous Annual Statement.”

Reason: To clarify the instructions.

5. Page 28, Schedule H

Insert an instruction after the title reading as follows:

“To be filed not later than May 1, 19\_\_\_\_\_.”

Reason: To correct an omission.

6. Page 39, Schedule T — Part 1

Rearrange Columnar Headings to follow the arrangement shown on page 14.

Reason: To facilitate comparison of page 14 with Schedule T — Part 1.

INSTRUCTIONS FOR FIRE AND CASUALTY BLANK

7. Instructions for Liabilities, Surplus and Other Funds — Page 3

(Page 1 of Instructions)

Add a new instruction as follows:

“ITEM — CAPITAL

See Instruction for Exhibit 2 — Item 23 — Company’s Stock Owned. The details of any such holdings, where permitted by State law, and all transactions relating thereto during the year shall be appropriately reported in or as a part of the Annual Statement.”

Reason: To elicit full information concerning these matters.

8. New instruction for Schedule F — Part 1A — Section 2

Assumed Reinsurance from Affiliated Companies — Page 25

(Page 5 of Instructions)

Add a new instruction reading as follows:

“SCHEDULE F — PART 1A — SECTION 2 — ASSUMED REINSURANCE  
FROM AFFILIATED COMPANIES — AS OF DECEMBER 31,  
CURRENT YEAR — PAGE 25

List names and location of all affiliated companies reinsured and enter data in the appropriate columns. Include (1) each insurer, a majority of the capital stock of which is owned or controlled by any or all of the stockholders, directors or officers of the reporting insurer who also own or control a majority of the capital stock of the reporting insurer, and (2) each other insurer which operates under the same management as the reporting insurer.”

Reason: To clarify the instructions.

9. New instructions to be printed at end of present Instructions.

Add a new section of instructions reading as follows:

“INSTRUCTIONS FOR COMPANIES ACTING  
AS MEDICARE FISCAL INTERMEDIARIES

Medicare Fiscal Intermediaries act as administrative agents for the Social Security Administration on a reimbursement basis. In general, accounting activity in connection with Medicare should be handled such that the financial results reflected in the various statements and exhibits of the Annual Statement of those companies acting as Medicare Fiscal Intermediaries under such contracts

are on a comparable basis to those of any other insurers. The following instructions should be applied for the particular transactions specified.

**Assets — Page 2**

Any excess of cash disbursements over cash received from the Social Security Administration and credited to Intermediaries' general accounts should be reported as a miscellaneous ledger asset.

Any amount in a bank account established under Medicare or similar programs should be excluded from assets.

**Liabilities — Page 3**

Any excess of cash received from the Social Security Administration over cash disbursements should be reported as a miscellaneous ledger liability.

**Part 4 — Page 10**

Intermediaries' administrative expense reimbursements should be credited to the individual accounts, such as salaries, rent, travel, etc. In other words, each line in this part should be reported on a net after reimbursement basis. Reimbursement for minor indirect expenses allocated to the Medicare operation may be credited in total in Line 21 — Miscellaneous.

**Exhibit 1 — Page 11**

**Equipment, Furniture and Supplies**

Company-owned equipment, furniture and supplies used in connection with Medicare operations should be reported as provided in the instruction for item 15 of this exhibit."

Reason: To provide for uniform reporting of these activities.

**LIFE AND ACCIDENT AND HEALTH BLANK**

10. Page 3, Items 29A, 29B and 30 — Change these items to read as follows:

29A	Gross paid in and contributed surplus	\$-----
29B	Unassigned surplus	-----
29C	Total of Items 29A and 29B	\$-----
30	Total of Items 27, 28 and 29C	-----

Reason: To provide a subtotal for Items 29A and 29B.

11. Page 4, Item 20

Change this caption to read as follows:

"20. Subtotal (Items 8 to 19A)".

Reason: To correct an error.

12. Page 4, Item 35A

Change this item to read as follows:

"35A. Gross paid in and contributed surplus December 31, previous year."

Reason: To correct an error.

13. Page 14, Exhibit 13, Line 12.3

Insert "-0-" in Column 4 and delete that part of the instruction for this line (Page 10 of Instructions) reading "Insert a zero (0) in Column (4)."

Reason: To be consistent with the treatment of the other divisions of Line 12.

14. Page 15, Exhibits of Insurance Policies, Line 19

Insert two reference marks (§§) in the "Amount" column under "Group Policies" and add the following to the §§ footnote:

"This company's participations in the Federal Employees Group Life Insurance Policy (FEGLI) and the Servicemen's Group Life Insurance Policy (SGLI) included in Line 19, follow: Number of Certificates — FEGLI \_\_\_\_\_ SGLI \_\_\_\_\_; Amounts of Insurance — FEGLI \$\_\_\_\_\_ SGLI \$\_\_\_\_\_."

Reason: To provide for the reporting of this information.

15. Page 17, General Interrogatory 23

Change this interrogatory to read as follows:

"23. Has any change been made during the year of this statement in the charter, by-laws, articles of incorporation or deed of settlement of the company? Answer \_\_\_\_\_ If so, when? \_\_\_\_\_ If not previously filed, furnish herewith a certified copy of the instrument as amended."

Reason: To add by-laws to the requirement and to provide an identifying date for checking submissions.

16. Page 33, Schedule F

Insert a new column between Columns 1 and 2, captioned "Claim Numbers" and renumber the columns.

Reason: To make it more convenient to find the claim file if necessary at the time of examination.

17. Page 35, Schedule H

Delete xx's from the % portion of Columns 3 to 6 of Line 12d and insert them instead in the corresponding columns of Line 15d.

Reason: To correct an error.

18. Page 43, Schedule S, Part 3C

Change the reference in the Note below this schedule from "Part 3B" to "Part 3C".

Reason: To correct an error.

19. Page 46, State Business Page

Add the following Note in the Policy Exhibit section:

"Note: This company's participations in the FEGLI and SGLI policies are shown in this Policy Exhibit as direct business."

Reason: To call attention to this requirement.

20. Page 46, State Business Page

Change lines 23 - 25 to read as follows:

"23. Group Policies

23A. Collectively Renewable Policies

24. Other Individual Policies

- a. Non-cancellable
- b. Guaranteed renewable
- c. Non-renewable for stated reasons only
- d. Other accident only
- e. All other
- f. Total (sum of a to e)

25. Totals (Lines 23+23A+24f)

Reason: To conform with the classifications used in other parts of the statement.

INSTRUCTIONS FOR LIFE AND ACCIDENT AND HEALTH BLANK

21. New instruction under "General" (Page 1 of Instructions)

Add a new Instruction 10 reading as follows:

"10. A consulting actuary who is not an officer or director of the insurer may attach one of the following affidavits in lieu of signing the jurat on Page 1 of the annual statement:

- (1) \_\_\_\_\_, consulting actuary of the \_\_\_\_\_, deposes and says that this annual statement has been prepared in accordance with the Instructions and other requirements applicable thereto and that the annual statement contains a full and true statement with respect to policy reserves, and all other items of an actuarial nature.
- (2) \_\_\_\_\_, consulting actuary of the \_\_\_\_\_, deposes and says that this annual statement contains a full and true statement with respect to policy reserves and all other items of an actuarial nature. (The latter may be described and limited in the affidavit as permitted or required by the State to which the statement is made)".

Reason: To assure compliance with the requirement that an actuary sign the statement.

22. New instruction under "General"

(Page 1 of Instructions)

Add a new Instruction 11 reading as follows:

"11. The qualifications of the actuary signing the statement, or of a consulting actuary executing an affidavit attached to the statement, are matters to be determined by the State to which the statement is submitted, under its laws, rulings or regulations. An actuary who is a member of the American Academy of Actuaries will be considered so qualified subject to any additional requirements which may be imposed by such State."

Reason: To provide recognition, as recommended by the NAIC Committee to Study Accreditation of Actuaries, of membership in the American Academy of Actuaries as the qualification of an actuary signing the statement.

23. Instruction for Liabilities, Surplus and Other Funds — Page 3, Item 28 — Capital

(Page 2 of Instructions)

Add the following Note to the present instruction:

"Note: See Instructions for Exhibit 14, Page 14, Line 27 — Company's Stock Owned. The details of any such holdings, where permitted by State law, and all transactions relating thereto during the year shall be appropriately reported in or as a part of the annual statement."

Reason: To elicit full information concerning these matters.

24. New instruction to be printed at end of present Instructions

Add a new section of instructions reading as follows:

**"INSTRUCTIONS FOR COMPANIES ACTING  
AS MEDICARE FISCAL INTERMEDIARIES**

Medicare Fiscal Intermediaries act as administrative agents for the Social Security Administration on a reimbursement basis. In general, accounting activity in connection with Medicare should be handled such that the financial results reflected in the various statements and exhibits of the Annual Statement of those companies acting as Medicare Fiscal Intermediaries under such contracts are on a comparable basis to those of any other insurers. The following instructions should be applied for the particular transactions specified.

**Assets — Page 2**

Any excess of cash disbursements over cash received from the Social Security Administration and credited to Intermediaries' general accounts should be reported as a miscellaneous ledger asset.

Any amount in a bank account established under Medicare or similar programs should be excluded from assets.

Liabilities — Page 3

Any excess of cash received from the Social Security Administration over cash disbursements should be reported as a miscellaneous ledger liability.

Exhibits 5 and 6 — Page 9

Intermediaries' administrative expense and tax reimbursements should be credited to the individual accounts, such as salaries, rent, travel, etc. In other words, each line in these Exhibits should be reported on a net after reimbursement basis. Reimbursement for minor indirect expenses allocated to the Medicare operation may be credited in total in Line 6.6 — Sundry General Expenses.

Exhibit 13 — Page 14

Furniture and Equipment

Company-owned furniture and equipment used in connection with Medicare operations should be reported as provided in the instruction for Line 12.3 of this exhibit."

Reason: To provide for uniform reporting of these activities.

SEPARATE ACCOUNT BUSINESS BLANK

25. Make changes corresponding to those adopted for the regular Life and Accident and Health Blank in Items 10, 11, 13, 14, 16, 17 and 20 of this report.

Reason: These items are also applicable to this blank.

26. (a) Page 4, Item 35

Delete this item and substitute for it two new items:

"35A. Gross paid in and contributed surplus December 31, previous year"

"35B. Unassigned surplus December 31, previous year".

- (b) Page 4, Item 50A

Change caption from "Gross paid in and contributed surplus" to "Gross paid in and contributed surplus December 31, current year (Item 29A, Page 3)".

- (c) Page 4, Item 50B

Change caption from "Unassigned surplus December 31, current year (Item 29, Page 3)" to "Unassigned surplus December 31, current year (Item 29B, Page 3)".

- (d) Page 8, Exhibit 4

In the \*\* footnote change "Exhibit 2, Line 4" to "Exhibit 2, Line 6".

- (e) Page 13, Exhibit 12, Line 37

Change the reference in the caption for this line from

"(Exhibit 4, Column 3 and Exhibit 2, Line 4)" to

"(Exhibit 4, Column 3 and Exhibit 2, Line 6)".

- (f) Page 36, State Business Page, Accident and Health Insurance (Total) Section

Change the heading of the third column from "Dividends and Retrospective Rate Credits Paid or Credited on Direct Business\*" to "Dividends Paid or Credited on Direct Business", and delete the \*'s from the headings for the "Direct Premiums Earned" and "Direct Losses Incurred" columns.

Reason: To correct errors.

FRATERNAL BLANK

27. Make changes corresponding to those adopted for the Life and Accident and Health Blank in Items 11, 17, 21 and 22 of this report, with "Page 36" substituted for "Page 35" in the reference for Item 17.

Reason: These items are also applicable to this blank.



## 28.(a) Pages 2, 3 and 4

Change the word "COMPANY" to "SOCIETY" in the heading for each of these pages.

## (b) Page 5, Items 7, 20 and 27

Page 13, Exhibit 9, Part A, Lines 5 and 7

Page 13, Exhibit 9, Part B, Lines 4, 6 and C

Page 14, Exhibit 11, Part 1, Line 4

Page 17, Exhibit of Certificates, Lines 5, 6 and 15

Page 17, Exhibits of Annuities, Line 4

Page 17, Classification of Annuities, Line 10

Change the words "TOTAL" to "TOTALS" and "SUBTOTAL" to "SUBTOTALS".

## (c) Page 14, Exhibit 11, Part 1, Column 8

Insert dagger (†) on lines 2.1, 2.2 and 3 to fit footnote.

## (d) Page 14, Exhibit 11, Part 2, Line 2

Change to read:

"Deduct reinsurance recovered".

## (e) Page 22, Schedule B, Part 2, Section 1

Capitalize the letter "S" in the word "Society" in the preamble.

## (f) Page 28, Schedule C, Part 3

Add the following footnote which was inadvertently omitted from the 1967 blank:

"NOTE: Substitutions of collateral need be shown in detail in only one exhibit. Refer in each of the other exhibits to the number of the loan in the exhibit in which the substitution is shown and show the substitutions in Part 1 when possible."

## (g) Page 30, Schedule D, Part 1

Add to dagger (†) footnote the following sentence which was inadvertently omitted from the 1967 blank:

"All Societies must report amortized values whether or not this basis of valuation is used on Page 2."

## (h) Page 36, Schedule H, Part 4, Line 31

Change to read as follows:

"Net Investment Income"

## (i) Page 36, Schedule H, State Business Section

Renumber these lines from 52-60 to 37-45.

## (j) Instruction for Exhibit 11, Part 1, Lines 2 and 3

(Page 8 of Instructions)

Change "Line 2.2" to "Line 2.1" in the last sentence of this instruction.

Reason: To correct errors.

## 29. Page 40, Schedule S

Substitute Schedule S, Parts 1, 2, 3A and 3B of the Life and Accident and Health Blank for present Schedule S. The new Parts will be printed on Pages 40 and 41, to be followed by Schedule X on Page 42 and Schedule T on Page 43. The following changes in the Life and Accident and Health Schedule S are necessary to conform to Fraternal requirements:

## (a) Schedule S — Part 1

Change the word "Companies" to "Reinsurers" in the heading.

(b) Schedule S — Part 3A

- (1) Delete the dagger (†) at the end of the heading.
- (2) Change parenthetical reference in column headed "Amount in Force at End of Year" to read "(To agree with Line 5, Page 14)".
- (3) Change parenthetical reference in column headed "Premiums" to read "(To agree with Line 26, Exhibit 1, Col. 1 less Cols. 4, 5, 6, 7 and 8)".

(c) Schedule S — Part 3B

- (1) Add the words "and Societies" to the heading after the word "Companies".
- (2) Delete the dagger (†) footnote and the "Note" footnote.
- (3) Delete General Interrogatories 2 and 3.

Reason: To make the reporting of reinsurance data consistent with that reported in the Life and Accident and Health Blank.

TITLE BLANK

30. Page 8, Exhibit 2, Line 19

Insert xxxx in Column 3.

Reason: No entry is permitted in this column at this line.

31. Instruction for Liabilities, Surplus and Other Funds — Page 3

(Page 1 of Instructions)

Add the following new instruction:

"ITEM 18 — CAPITAL

See Instruction for Exhibit 2 — Item 19 — Company's Stock Owned. The details of any such holdings, where permitted by State law, and all transactions relating thereto during the year shall be appropriately reported in or as a part of the Annual Statement."

Reason: To elicit full information concerning these matters.

HOSPITAL, MEDICAL AND DENTAL SERVICE OR  
INDEMNITY CORPORATIONS BLANKS

32. Page 3, Item 1

Add a second parenthetical item as follows:

"(Includes provision for retroactive cost adjustments \$\_\_\_\_\_)"

Reason: To provide this additional information.

33. New instructions to be printed at end of present Instructions

Add a new section of instructions reading as follows:

"INSTRUCTIONS FOR COMPANIES ACTING AS MEDICARE OR SIMILAR  
NON-UNDERWRITING FISCAL INTERMEDIARIES AND/OR CARRIERS.

Assets — Page 2

Any excess of cash disbursements over cash received from Medicare or similar non-underwritten programs should be reported as a miscellaneous asset item.

Any amount in a separate bank account for exclusive use of Medicare or similar non-underwritten programs should be reported under Item 6, Page 2.

Liabilities — Page 3

Any excess of cash received over cash disbursements for Medicare or

similar non-underwritten programs should be reported as a miscellaneous liability item.

**Part 3 and 3A — Page 7**

Report gross operating expenses in Part 3A and enter as a subtraction at Item 16 the amount representing reimbursement for Medicare or similar non-underwritten programs. Thus, the resultant totals on line 17 and in Part 3 will be on a net, after reimbursement, basis.

**Exhibit 1 — Page 9**

**Furniture and Equipment — Item 20A**

Company-owned furniture and equipment used in connection with Medicare or similar non-underwritten programs should be reported as provided in the instructions for line 20A of this exhibit. In other words, it must be carried at zero value in column 4, Net Admitted Assets.

Reason: To provide for uniform reporting of these activities.

**ACTION TAKEN ON OTHER MATTERS**

**34. Date of Next Meeting**

Next Spring's meeting will be held during the week beginning March 17, 1969.

**35. Item Left on Agenda for June Meeting in Portland**

Consideration of proposed changes in Schedule P (Exhibit F of Agenda) deferred to await such recommendations in respect thereto as the Laws and Legislation Committee and the Property, Casualty and Surety Insurance Committee may make at the NAIC meeting scheduled to be held in Portland, Oregon, in June of this year.

**36. Items Deferred for Further Study**

- (a) Treatment of mortgage escrow funds (Exhibit B of Agenda) recommended to be referred to the Examination Manual Revision Subcommittee.
- (b) Proposal to re-number present schedules, exhibits, parts and items of the Fire and Casualty Blank, (Exhibit H of Agenda) and of the Life and Accident and Health Blank (Exhibit M of Agenda).
- (c) Proposal to amend Schedule E of Life and Accident and Health Blank (Exhibit D of Agenda).
- (d) Proposal to amend Exhibits of Life Insurance Policies (Exhibit J of Agenda). It is noted that Industry is preparing revisions of these exhibits which will be submitted to the Blanks Committee later this year.
- (e) Proposal for uniform accounting of Deposit Administration and Special Accounts funds (Exhibit K of Agenda) recommended to be referred to the Special Subcommittee on the Revision of Statement for Separate Account Business.
- (f) Proposal to amend the Hospital, Medical and Dental Service or Indemnity Corporations Blank to provide a separate classification for "Individual eligible for Medicare" (Exhibit P of Agenda).

SUBCOMMITTEES APPOINTED

Fire, Casualty and Reciprocal Blank Subcommittee

William C. Gould, Chm.	N. Y.	Ernest J. Meredith	Md.
E. J. Voorhis, Jr., V.Chm.	Texas	George F. Howarth	Mass.
Christy P. Armstrong	Calif.	Robert Bailey	Mich.
Charles A. Spoerl	Conn.	Walter J. Madden	Nebr.
Frank de Veer	Fla.	W. Harold Bittel	N. J.
T. Donald Karnes	Ill.	Richard W. Krimm	Pa.
Everett Westbrook	Ind.	Francis T. McGovern	R. I.
Robert B. Evans	Ky.	Woodrow W. Paris	Va.
Sidney O. Robertson	La.	Donald D. Bower	Wash.

Life, Accident and Health Blank Subcommittee

W. Harold Bittel, Chm.	N. J.	Ernest J. Meredith	Md.
Donald R. Gilliland	Ariz.	George F. Howarth	Mass.
Christy P. Armstrong	Calif.	Wm. C. Conley	Mich.
Lloyd J. Engstrom	Colo.	Walter J. Madden	Nebr.
Charles A. Spoerl	Conn.	I. Murray Krowitz	N. Y.
Frank de Veer	Fla.	Richard W. Krimm	Pa.
Herbert B. Sturtevant	Ga.	Francis T. McGovern	R. I.
T. Donald Karnes	Ill.	Henry G. Eggert	Tenn.
Lou Smith	Ind.	E. J. Voorhis, Jr.	Texas
Robert B. Evans	Ky.	John H. Parker	Va.
Sidney O. Robertson	La.	Donald D. Bower	Wash.

Fraternal Blank Subcommittee

Francis T. McGovern, Chm.	R. I.	Walter J. Madden	Nebr.
Christy P. Armstrong	Calif.	Thomas J. Kelly	N. Y.
Bernard Risse	Ill.	Richard W. Krimm	Pa.
Everett Westbrook	Ind.	Donald D. Bower	Wash.
George F. Howarth	Mass.		

Hospital and Medical Service Plans Blank Subcommittee

George F. Howarth, Chm.	Mass.	William C. Gould	N. Y.
William C. Conley	Mich.	Richard W. Krimm	Pa.
Walter J. Madden	Nebr.	Francis T. McGovern	R. I.
W. Harold Bittel	N. J.		

Title Insurance Blank Subcommittee

William C. Gould, Chm.	N. Y.	W. Harold Bittel	N. J.
Christy P. Armstrong	Calif.	Richard W. Krimm	Pa.
George F. Howarth	Mass.	E. J. Voorhis, Jr.	Texas
Robert A. Bailey	Mich.	Donald D. Bower	Wash.
Walter J. Madden	Nebr.		

Welfare and Pension Fund Blanks Subcommittee

James J. Higgins, Chm.	N. Y.	J. W. Vilberg	Wis.
Donald D. Bower	Wash.		

Conflict of Interest Subcommittee

W. Harold Bittel, Chm.	N. J.	Walter J. Madden	Nebr.
Christy P. Armstrong	Calif.	William C. Gould	N. Y.
Ernest J. Meredith	Md.	E. J. Voorhis, Jr.	Texas

Revision of Statement for Separate Account Business Subcommittee

W. Harold Bittel, Chm.	N. J.	I. Murray Krowitz	N. Y.
Francis C. Jumouville	La.		

To Study Terminology Proposals Blanks Subcommittee

W. Harold Bittel, Chm.	N. J.	Walter J. Madden	Nebr.
Christy P. Armstrong	Calif.	I. Murray Krowitz	N. Y.
J. Arthur Wedgeworth	Mass.	E. J. Voorhis, Jr.	Texas

To Prepare Uniform Page for Annual Statement Blank to be Used by States  
in Preparation of Annual Reports of Commissioners of Each State

Christy P. Armstrong, Chm.	Calif.	W. Harold Bittel	N. J.
Charles A. Spoerl	Conn.	William C. Gould	N. Y.

To Study Reporting of "Adjusted Earnings" by Life Companies

John W. Riley, Chm.	Ky.	James H. Hunt	Vt.
Lorne R. Worthington	Iowa	Robert D. Haase	Wis.
Thomas J. Kelly	N. Y.		

Respectfully submitted, Hon. James H. Hunt, Chm., Vt.; Hon. Richard S. L. Roddis, V.Chm., Calif.; Hon. G. A. Bushnell, Ariz.; Hon. Broward Williams, Fla.; Hon. James L. Bentley, Ga.; Hon. Joseph G. Wood, Ind.; Hon. Frank Sullivan, Kans.; Hon. Robert D. Preston, Ky.; Hon. David J. Dykhouse, Mich.; Hon. Benjamin C. Neff, Jr., Nebr.; Hon. Charles R. Howell, N. J.; Hon. Richard E. Stewart, N. Y.; Hon. David O. Maxwell, Pa.; Hon. David M. Pack, Tenn.; Hon. Clay Cotten, Texas; Hon. T. Nelson Parker, Va.; Hon. Lee I. Kueckelhan, Wash.; Hon. Robert D. Haase, Wis.

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Fire, Casualty and Reciprocal Blank (A5a) Subcom. Report  
(Mtg. 40)

The Fire, Casualty and Reciprocal Blank Subcommittee convened in Special Meeting Wednesday, June 19, 1968, in Ballroom "B" of the Hilton Hotel.

The only item for consideration by the Subcommittee was the action to be taken to implement the earlier action of the Laws and Legislation (D) and Property, Casualty and Surety Insurance (F) Committees, the effect of which was to adopt (1) Proposed Model Legislation to Modify Schedule "P" Statutes and the Proposed Specification Changes in the said Schedule of the Fire & Casualty Annual Statement Blank, which are attached to and form a part of the Actuarial (F5) Subcommittee Report of June 17, 1968.

After appropriate consideration of the matter, a motion was adopted to effectuate the stated changes in Schedule "P" the same to be effective with the filing of Annual Statements for the Year 1969, with appropriate changes to conform to the newly proposed effective data.

Hon. William C. Gould, Chm., N. Y.; Hon. E. J. Voorhis, Jr., V.Chm., Tex.; Hon. Christy P. Armstrong, Calif.; Hon. Chas. A. Spoerl, Conn.; Hon. Frank de Veer, Fla.; Hon. T. Donald Karnes, Ill.; Hon. Everett Westbrook, Ind.; Hon. Robt. B. Evans, Ky.; Hon. Sidney O. Robertson, La.; Hon. Ernest J. Meredith, Md.; Hon. George F. Howarth, Mass.; Hon. Robert A. Bailey, Mich.; Hon. Robert E. Holliday, Mo.; Hon. Walter J. Madden, Nebr.; Hon. W. Harold Bittel, N. J.; Hon. Richard W. Krimm, Pa.; Hon. Francis T. McGovern, R. I.; Hon. John W. Washington, Tenn.; Hon. Woodrow W. Paris, Va.; Hon. Donald D. Bower, Wash.

Report of Subcommittee to Study Terminology Proposals  
to the NAIC Committee on Blanks

A meeting of the Subcommittee to Study Terminology Proposals was held during the sessions of the Blanks Committee in New York at the Americana Hotel on Wednesday, March 27, 1968. A copy of the Recommendations of the Subcommittee on Blanks of the Health Insurance Association of America contained in a letter to the Chairman dated January 30, 1967 from Mr. A. C. Olshen had previously been sent to the members of the Subcommittee.

The Subcommittee concluded that there are several aspects of the Industry proposal which make it unacceptable and therefore recommends that it not be adopted at this time. The phrase "Health Insurance" which Industry recommends as an appropriate generic term for describing the business which is now reported as "Accident and Health Insurance" does not in our opinion properly describe a policy which provides benefits only in the event of accidental death. There also is in the current statement a column headed "Other Accident Only" which again is not appropriately described by this term "Health Insurance."

It was the feeling of the Subcommittee that if Industry desires a change in the terminology of the annual statement blanks it should first seek amendments of existing laws in many states which not only contain no reference to "Health Insurance", as such in this sense but actually define this term as relating only to policies or contracts which insure against disablement, disease or sickness of the insured, excluding disablement which results from accident or from accidental means. We do not feel that any change can be made in the terminology used for the annual statement blank until these laws have been amended to eliminate this inconsistency.

Hon. W. Harold Bittel, Chm., N. J.; Hon. Christy P. Armstrong, Calif.;  
Hon. J. Arthur Wedgeworth, Mass.; Hon. Walter J. Madden, Nebr.;  
Hon. I. Murray Krowitz, N. Y.; Hon. E. J. Voorhis, Jr., Texas.

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## MEXICO INSURANCE PROBLEMS (A6) COMMITTEE

AGENDA - MTG. #29

TUESDAY A.M.

JUNE 18, 1968

9:00-10:15

PARLOR C

## Reference

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1968 Proc. VOL. I pp. 63-66

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1. Automobile Insurance Sources.
  2. Any other matter submitted for consideration.
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MEXICO INSURANCE PROBLEMS (A6) COMMITTEE Report  
(Mtg. 29)

The meeting of the Mexico Insurance Problems (A6) COMMITTEE was held Tuesday, June 18, 9 a.m., in Parlor C of the Portland Hilton Hotel, Portland, Oregon. A quorum was present. The problem presented by the invalidity of United States insurance coverage in Mexico was again discussed.

Commissioner Mastos of Nevada reported that contacts have been made with certain American agents and Mexican companies, whereby coverage can be issued by the American agents in a Mexican company, thus making such coverage valid in Mexico.

It was suggested that a joint Industry Committee be created to give further study to this problem and, hopefully, reach a solution by means of facilitating the issuance of Mexican insurance policies through American company and agency channels. This being the only means of satisfactorily dealing with this matter, until such time as constitutional changes are made in Mexico to allow insurance in American companies to become valid in Mexico.

It was also moved and adopted that a recommendation be made to the NAIC that the name of this COMMITTEE be changed to the COMMITTEE ON INTERNATIONAL INSURANCE LIAISON, and that the duties of this COMMITTEE be expanded to encompass all matters which might come before the NAIC dealing with the insurance industry or regulatory officials of all foreign countries.

Hon. Walter S. Houseal, Chm., Ala.; Hon. Ralph F. Apodaca, V.Chm., N. M.; Hon. Jerry P. Shea, Ariz.; Hon. Richard S. L. Roddis, Calif.; Hon. J. Richard Barnes, Colo.; Hon. Dudley A. Guglielmo, La.; Hon. Louis T. Mastos, Nev.; Hon. Clay Cotten, Texas.

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## CIVIL DISORDERS — INSURANCE PROBLEMS (A7) COMMITTEE

## AGENDA - MTG. #30

TUESDAY A.M.

JUNE 18, 1968

9:00-10:15

BALLROOM B

## Reference

1968 Proc. VOL. I pp. 69-78

1. CIVIL DISORDERS — INSURANCE PROBLEMS (A7) COMMITTEE Reports (Meetings 2/7/68, New York, N. Y. and 5/10/68, Richmond, Va.)
2. Any other matter submitted for consideration.

## CIVIL DISORDERS — INSURANCE PROBLEMS

## (A7) COMMITTEE (Mtg. 30)

A meeting of the Committee was held in Ballroom B of the Portland-Hilton Hotel on June 18, 1968. A quorum was present. Commissioner T. Nelson Parker, Chairman, presided, and presented a summary Report of previous meetings held in New York City on February 7, 1968 (ref: 1968 Proc. Vol. II pages 387-389), and Richmond, Virginia on May 10, 1968. He stated that the Industry Property Insurance Liaison Committee had submitted a tentative program dealing with the matter of expanding the market for property insurance in urban areas. The Chairman further stated that it was his understanding that a Model Uniform Basic Property Insurance Inspection and Placement Program was to be submitted at the Portland Meeting by the Industry Liaison Committee comprised of representatives of the three major company trade associations — American Insurance Association, American Mutual Insurance Alliance and National Association of Independent Insurers. The Chairman called upon Mr. O. C. Griffith of the Shelby Mutual Insurance Company who introduced George H. Brown, Secretary to the Industry Liaison Committee. Mr. Brown outlined the background and scope of the problem and summarized the basic property insurance placement program, a copy of which is attached.

Mr. Brown, representing American Insurance Association, Mr. Arthur Mertz of National Association of Independent Insurers and Mr. F. A. Holderman of American Mutual Insurance Alliance urged that the Committee endorse the industry program.

The Chairman then called for the submission of any other plans. Insurance Company of North America, represented by Edmond Rondepierre, submitted a statement favoring a program providing solely for a pool rather than a FAIR Plan. Placement Facility and Joint Reinsurance Association.

A copy of the INA statement is attached. The Factory Mutuals, represented by Ambrose B. Kelly, generally supported the INA proposal. Both speakers endorsed the objectives of the FAIR Plan Program. The Committee recognized, however, that enabling legislation will have to be enacted in order to implement any program.

The Committee believes that the next important step in the process of developing sound and stable property insurance markets in the respective States is the creation and implementation of plans which will provide insurance for insurable properties in those cases where the private insurance industry is not furnishing such insurance.

The Committee carefully considered the various industry submissions concerning the mechanism for distributing risks and for administering the program, noting that industry representatives had urged that the Committee endorse the industry plans as a uniform, detailed plan of operation to be adopted by the several States.

The Committee concluded that the administrative and distributive mechanism should be adapted by each State to the condition of its own insurance market. In the judgment of the Committee, it is important for Insurance Commissioners as government officials, representing the public, to continue to pursue as their highest priority, the establishment of an adequate, stable and continuous market for basic property insurance, especially in urban areas, recognizing that an adequate supply of basic property insurance is essential to orderly community development.

The Committee believes that other concerns, such as the specifics of administration and distribution are important, but, from the state supervisory officials point of view, secondary to the goal of strengthening the market.

The Committee believes that while the mechanics should be adapted to conditions in various States, it is appropriate for the NAIC to set out general criteria to be considered by Commissioners in developing and reviewing plans for the provisions of basic property insurance in their respective States:

- (a) Availability. The basic, fundamental purpose of any acceptable plan must be to assure availability of basic property insurance (defined as the standard fire policy and extended coverage endorsements plus such allied lines as seem appropriate to conditions in a particular State) to all insurable property risks in a State. Availability should be practical as well as theoretical. Facilities providing this insurance should be readily and conveniently accessible to property owners. Plans should be of sufficient duration as to assure the public that an insurance

market will be available at all times. In addition, grounds for cancellation during the policy term should be severely curtailed.

- (b) Insurability. Plans should contain provisions setting standards of insurability to assure that the standards for the physical condition and the nature of occupancy and use of eligible property are in accordance with sound public policy. At the same time, however, property should not be determined to be un-insurable because of its location or because of hazard external to the property and beyond the control of the owner or occupant.
- (c) Equity. Plans should be so structured that the essential interest of the public and the insurers are protected and equitably balanced. An equitable structure should include at least the following elements:
  - (1) The insurance capacity of the plan should be sufficient to meet all foreseeable demands upon it.
  - (2) Risks assumed should be spread among insurers on a basis that reasonably reflects each individual insurers share of the relevant insurance market in that State.
  - (3) A plan of operation should be constructed so as to qualify participating insurers for reinsurance under appropriate Federal Legislation implementing the national aspects of the recommendations of the National Advisory Panel on Insurance in riot affected areas.
  - (4) Production allowances, if fixed, should be at levels that neither unduly induce nor discourage participation in the plan.
- (d) Simplicity. Plans should be as simple as possible in structure and operation. Procedure should be able to be readily understood by producers and applicants for insurance and be designed speedily and efficiently to determine eligibility of property and to provide insurance for such property.

The internal mechanism of the plan should also be as simple as practicable. Elaborate devices for splitting markets or unduly complicating internal operations should be avoided. The plan should be designed so as to function effectively without detailed day by day supervision by state supervisory officials.

In addition, the Committee reaffirms the position of the NAIC in support of Catastrophe Reserve-Tax Deferral Program and urges the U. S.

Congress to pass the necessary legislation to allow the implementation of such program.

Hon. T. Nelson Parker, Chm., Va.; Hon. George M. Cowden, V.Chm., Texas; Hon. Richard S. L. Roddis, Calif.; Hon. John F. Bolton, Jr., Ill.; Hon. David J. Dykhouse, Mich.; Hon. Richard E. Stewart, N. Y.; Hon. Eugene P. Brown, Ohio.

### Model Uniform Basic Property Insurance Inspection and Placement Program

The Uniform Basic Property Insurance Inspection and Placement Program (hereinafter referred to as the Program) has been formulated by the insurance industry for the purpose of making Basic Property Insurance available to responsible applicants for such insurance who have been unable to secure such insurance in the normal insurance market.

#### Section I — Purposes of Program

The purposes of the Program are:

- (1) to make Basic Property Insurance available, subject to the conditions hereinafter stated;
- (2) to establish a FAIR Plan (Fair Access to Insurance Requirements), an Industry Placement Facility and a Joint Reinsurance Association for the equitable distribution and placement of risks among Insurers in the manner and subject to the conditions hereinafter stated.

#### Section II — Effective Date

(1) The Program shall become effective on (Date), but in no event prior to the effective date of the National Insurance Development Corporation Act of 1968, or such other title as such federal legislation may bear upon enactment (hereinafter referred to as the Act).

(2) The Program is intended to conform with the applicable provisions of the Act.

#### Section III — Definitions

(1) "Insurer" means any insurance company or other organization licensed to write and engaged in writing property insurance business, including the property insurance components of multi-peril policies, on a direct basis, in this state, except where such Insurer is specifically exempted by statute from participation in this Program.

(2) "Basic Property Insurance" means the coverage against direct loss to real and tangible personal property at a fixed location that is provided in the Standard Fire Policy and Extended Coverage Endorsement and such vandalism and malicious mischief insurance and such other classes of insurance as may be added to the Program with respect to said property by amendment as hereinafter provided. Basic Property Insurance does not include automobile, farm or manufacturing risks.

(3) "Industry Placement Facility" (hereinafter referred to as the Facility) means the organization formed by Insurers to assist applicants in Urban Areas in securing Basic Property Insurance and to administer the FAIR Plan and the Joint Reinsurance Association.

(4) "Inspection Bureau" means the fire insurance rating organization designated by the Facility with the approval of the Commissioner to make inspections as required under this Program and to perform such other duties as may be authorized by the Facility.

(5) "Urban Area" means any community having a blighted, deteriorated or deteriorating area (a) which the Secretary of the U. S. Department of Housing and Urban Development has approved as eligible for an urban renewal project after a local public agency has been formed in that community to avail itself of a U. S. Housing and Urban Renewal Program or (b) which the Facility has designated with the approval of the Commissioner or (c) which the Commissioner has designated.

(6) "Premiums Written" means gross direct premiums (excluding the portion of premium on risks ceded to the Joint Reinsurance Association) charged during the second preceding calendar year with respect to property in this state on all policies of Basic Property Insurance and the Basic Property Insurance premium components of all multi-peril policies, as computed by the Facility, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits.

(7) "Habitational" means Basic Property Insurance included under the Personal Lines Statistical Plan.

(8) "Commercial" means Basic Property Insurance not included under the Personal Lines Statistical Plan.

(9) "Commissioner" means the Commissioner of \_\_\_\_\_ of the State of \_\_\_\_\_ (chief regulatory official of Insurance Department).

#### Section IV — FAIR Plan — Inspections and Reports

(1) Any person having an insurable interest in real or tangible personal property at a fixed location in an Urban Area who certifies to the Facility that he has been unable to obtain Basic Property Insurance shall, upon payment of a deposit on account of the premium which may be payable, be entitled, upon application therefor to the Facility, to an inspection of the property by the Inspection Bureau.

(2) The manner and scope of the inspections of FAIR Plan business shall be prescribed by the Facility with the approval of the Commissioner.

(3) An inspection report shall be made for each property inspected. The report shall cover pertinent structural and occupancy features as well as the general condition of the building and surrounding structures. A representative photograph of the property may be taken during the inspection.

(4) During the inspection, the inspector shall point out features of structure and occupancy to the applicant or his representative and shall indicate those features which may result in condition charges if the risk is accepted. The inspector shall have no authority to advise whether any Insurer will provide the coverage.

(5) After the inspection, a copy of the completed inspection report, and any photograph, indicating the pertinent features of building, construction, maintenance, occupancy and surrounding property shall be sent promptly to the Facility for distribution to the Insurer or Insurers designated by the Facility. Included with the report shall be a rate make-up statement, including any condition charges or surcharges imposed by inspection or under the Program, or under any substandard rating plan approved by the Commissioner. A copy of the inspection report shall be made available to the applicant or his agent upon request.

#### Section V — FAIR Plan Business — Distribution and Placement

(1) The Facility, upon receipt of the applications for coverage and the inspection reports from the Inspection Bureau shall distribute risks to Insurers in the Facility in the manner hereinafter provided.

(2) The Facility shall distribute the Habitational risks which are eligible under this program among the Insurers so that each Insurer will receive the same proportion of FAIR plan premium as its Habitational Premiums Written bear to the aggregate Habitational Premiums Written by all Insurers in the FAIR Plan.

(3) The Facility shall distribute the Commercial risks which are eligible under this Program among the Insurers so that each Insurer will receive the same proportion of FAIR Plan premium as its Commercial Premiums Written bear to the aggregate Commercial Premiums Written by all Insurers in the FAIR Plan.

(4) Assessments upon each Insurer in the FAIR Plan for expenses in connection with FAIR Plan business shall be levied and assessed by the Governing Committee of the Facility on the same basis as the Habitational and Commercial risks are distributed pursuant to sub-sections (2) and (3) of this Section.

(5) Insurers which did not write any Basic Property Insurance business during the preceding five years in a given county may notify the Facility of their election not to accept referrals in that county from the Facility, provided such election is made at least ninety days prior to the beginning of each calendar year.

(6) Insurers, in order to facilitate placement, shall notify the Facility of the normal limits of liability they are willing to accept on each class of occupancy of Habitational and Commercial Basic Property Insurance risks under the Program, subject to a minimum liability of \$5,000 per risk. The Facility may submit any risk to more than one Insurer, but in no event to more than five Insurers.

(7) The maximum limits of liability which may be placed through this Program are:

on any Habitational property at one location, \$100,000; and on any Commercial property at one location, \$500,000. The word "location" as used herein means real and personal property consisting of and contained in a single building or consisting of and contained in contiguous buildings under one ownership.

#### Section VI — Procedure After Inspection and Submission

(1) Any Insurer (s) to which a risk is referred by the Facility shall, within three business days after receipt of the inspection report and application, complete an action report and return the same to the Facility advising that:

- (a) the risk is acceptable, or
- (b) the risk will be acceptable if the improvements noted in the action report are made by the applicant and confirmed by reinspection, or
- (c) the risk is not acceptable for the reasons stated in the action report.

(2) If the risk is accepted by the designated Insurer, the Facility shall deliver the policy or binder to the applicant upon payment to the Facility of the balance of the premium. The premium, less any commission payable, shall be remitted to the designated Insurer by the Facility.

(3) In the event a risk is declined because it fails to meet reasonable underwriting standards, the Facility will so notify the applicant and return the deposit premium. Reasonable underwriting standards shall include, but not be limited to, the following:

- (a) physical condition of the property, such as its construction, heating, wiring, evidence of previous fires or general deterioration;
- (b) its present use or housekeeping, such as vacancy, overcrowding, storage of rubbish or flammable materials;
- (c) violation of law, public policy or morals and the character or integrity of the property owner or occupants.

Neighborhood or area location or any environmental hazard beyond the control of the property owner shall not be deemed to be acceptable criteria for declining a risk.

(4) In the event the risk is conditionally declined because the property does not meet reasonable underwriting standards but can be improved to meet such standards, the Facility shall promptly advise the applicant what improvements noted in the action report should be made to the property. Upon completion of the improvements by the applicant or property owner, the Facility, when so notified, will have the property promptly reinspected and furnish the new inspection report to the previously designated Insurer (s).

(5) If the inspection of the property reveals that there are one or more substandard conditions, surcharges may be imposed in conformity with the substandard rating plan approved by the Commissioner.

(6) If the risk has been declined by the designated Insurer by reason of overlining, the Facility shall promptly submit the inspection report to another Insurer, and the declining Insurer shall not receive credit therefor.

(7) Any risk which has been accepted by an Insurer under the FAIR Plan, may be renewed by the same Insurer and credit will be given to said Insurer against its share of FAIR Plan business.

(8) Any Insurer, which is a member of a group of Insurers under the same management or ownership, to which a referral is made under the Program, may apply in behalf of the group for a combined distribution and placement quota under the Program. Such group shall have the option of designating the Insurer within the group to which the risk shall be referred.

#### Section VII — Joint Reinsurance Association

(1) A Joint Reinsurance Association (hereinafter referred to as the Association) shall be created consisting of all Insurers.

(2) The Association shall be authorized to assume reinsurance on behalf of Insurers and cede reinsurance on behalf of Insurers on eligible risks written by Insurers through the FAIR Plan. The reinsurance assumed by the Association shall be limited to:

- (a) all or any part of a risk which has a significant exposure hazard beyond the control of the insured;

(b) that portion of Basic Property Insurance placed through the FAIR Plan which exceeds the normal limits Insurers are willing to accept.

(3) Each Insurer shall participate in the writings, expenses, profits and losses of the Association in the following manner :

(a) for Habitational risks, the same proportion as its Habitational Premiums Written bear to the aggregate Habitational Premiums Written by all Insurers in the Program ;

(b) for Commercial risks, the same proportion as its Commercial Premiums Written bear to the aggregate Commercial Premiums Written by all Insurers in the Program,

#### Section VIII — Standard Policy Coverage

All policies issued shall be for Basic Property Insurance on standard policy forms and shall be issued for a term of one year.

#### Section IX — Cancellation

(1) No Insurer shall cancel a policy or binder issued under this Program except for :

(a) cause which would have been grounds for non-acceptance of the risk had such cause been known to the Insurer at the time of acceptance ; or

(b) for non-payment of premium ; or

(c) with the approval of the Governing Committee.

(2) Notice of cancellation, together with a statement of the reason therefor, shall be sent to the insured and a copy sent to the Facility.

(3) Any cancellation notice to the insured shall be accompanied by a statement that the insured has a right of appeal as hereinafter provided.

#### Section X — Right of Appeal

Any applicant or Insurer shall have the right of appeal to the Governing Committee. A decision of the Committee may be appealed to the Commissioner within 30 days from the action or decision of the Committee. Each denial of insurance shall be accompanied by a statement that the applicant has a right of appeal.

#### Section XI — Commission

Commission under the Program shall be ----- per cent on the policy premium and shall be paid to the licensed producer designated by the applicant.

#### Section XII — Administration

(1) This Program shall be administered by a Governing Committee (hereinafter referred to as the Committee) of the Facility and operated by a Manager appointed by the Committee.

(2) The Committee shall consist of five Insurers, one of which shall be elected from each of the following :

American Insurance Association  
 American Mutual Insurance Alliance  
 National Association of Independent Insurers  
 All other stock Insurers  
 All other non-stock Insurers

Not more than one Insurer in a group under the same management or ownership shall serve on the Committee at the same time.

#### Section XIII — Annual and Special Meetings

(1) There shall be an annual meeting of the Insurers on a date fixed by the Committee. The three aforementioned Associations shall designate or elect their representatives to the Committee. The two non-association groups of companies shall elect their respective representatives by majority vote counted on a weighted basis in accordance with each Insurer's Premiums Written and the aggregate Premiums Written for all Insurers in the respective groups of companies. Representatives on the Committee shall serve for a period of one year or until successors are elected or designated.

(2) A special meeting may be called at such time and place designated by the



Committee or upon the written request to the Committee of any ten Insurers, not more than one of which may be in a group under the same management or ownership.

(3) Twenty days' notice of such annual or special meeting shall be given in writing by the Committee to Insurers. A majority of the Insurers shall constitute a quorum. Voting by proxy shall be permitted. Notice of any meeting shall be accompanied by an agenda for such meeting.

(4) Any matter, including amendment of this Program, may be proposed and voted upon by mail, provided such procedure is unanimously authorized by the members of the Committee present and voting at any meeting of the Committee. If so approved by the Committee, notice of any proposal shall be mailed to the Insurers not less than twenty days prior to the final date fixed by the Committee for voting thereon.

(5) At any regular or special meeting at which the vote of the Insurers is or may be required on any proposal, including amendment to this Program, or any vote of the Insurers which may be taken by mail on any proposal, such votes shall be cast and counted on a weighted basis in accordance with each Insurer's Premiums Written. On any proposal, deemed by the Committee to relate exclusively to Habitational or exclusively to Commercial business, the votes shall be cast and counted on a weighted basis in accordance with each Insurer's respective Habitational or Commercial Premiums Written, as the case may be. A proposal shall become effective when approved by at least two-thirds of the votes cast on such weighted basis.

(6) Any amendment of the program shall be subject to approval by the Commissioner.

Section XIV — Duties of the Committee

(1) The Committee shall meet as often as may be required to perform the general duties of administration of the Program or on the call of the Commissioner. Three Insurers of the Committee shall constitute a quorum.

(2) The Committee shall be empowered to appoint a Manager, who shall serve at the pleasure of the Committee, to budget expenses, levy assessments, disburse funds and perform all other duties provided herein or necessary or incidental to the proper administration of the Program. The adoption of or substantive changes in pension plans or employee benefit programs shall be subject to approval of Insurers. Assessments upon each Insurer shall be levied on the basis of its Premiums Written.

(3) Annually the Manager shall prepare an operating budget which shall be subject to approval of the Committee. Such budget shall be furnished to the Insurers after approval. Any contemplated expenditure in excess of or not included in the annual budget, shall require prior approval by the Committee.

(4) The Committee shall furnish to all Insurers and to the Commissioner a written report of operations annually in such form and detail as the Committee may determine.

Section XV — Termination of the Program

This Program shall terminate on (Date), but in no event shall be of any force and effect after the expiration of the National Insurance Development Corporation Act of 1968, or at such earlier date at which the Program provided hereunder shall no longer qualify for riot or civil disorder reinsurance under the National Insurance Development Corporation Act. Notwithstanding the foregoing, any obligations incurred by the Association shall not be impaired by the expiration of the Program and such Association shall be continued for the purpose of performing such obligations.

Membership Agreement

The undersigned Insurer hereby ratifies and becomes a member of the \_\_\_\_\_  
 Basic Property Insurance Inspection and Placement Program, the \_\_\_\_\_  
 Industry Placement Facility and the \_\_\_\_\_ Joint Reinsurance Association  
 and assumes all of the rights and duties in connection therewith.

Dated:

-----  
 Insurer  
 By: -----  
 Chief Executive Officer

INSURANCE COMPANY OF NORTH AMERICA  
STATEMENT BEFORE  
CIVIL DISORDERS — INSURANCE PROBLEMS (A7) COMMITTEE

June 18, 1968

Since the Committee's last meeting in Honolulu, federal legislation concerning riot insurance has reached relatively final form, and appears to have a good chance for enactment; state legislation has been enacted in several jurisdictions and is under active development in a number of others. The federal legislation will, we believe, enable us to serve the urban market by affording protection against the gross catastrophe which might conceivably arise out of such man-made losses (which we earnestly hope will never occur). That federal legislation has our strong support.

In our presentations to the Congress and federal agencies, we have emphasized that what is needed is a stand-by federal back-up against these almost unthinkable losses; we do not need relief from ordinary losses — even from "ordinary" riots — nor do we want the Federal Government involved in the day-to-day operation of our business.

In the Committee's last meeting it concluded, "The broadest possible distribution of the financial burden of the riot and civil commotion hazard at the local, state, and national level is necessary to the end that the underwriting deterrent which unlimited exposure to these perils creates may be alleviated." INA is in complete agreement with this statement.

Our concern now is that plans offered to implement the federal program, and NAIC's purpose as expressed above, may not accomplish these goals.

Specifically, there have been numerous proposals for a system (described as the "FAIR" Plan) under which risks would be assigned to individual companies. This method of providing a readily available insurance market is most unfair to insurance companies. It is obvious that hazards will vary as among risks, and equally obvious that the relative inadequacy of rate will vary as among risks. The number of risks to be assigned and the concentration of losses in relatively limited geographic areas preclude an equitable allocation of risk by such random assignments.

In addition to being unfair to primary carriers, this method of assignment is most unfair to reinsurers. Federal and state agencies specifically acknowledge that the rates for the business being assigned are and will continue to be generally inadequate. While the federal agency will provide reinsurance for losses arising out of riot and civil disorder, the private reinsurer will be expected to absorb all other losses on this business. In fact, there is no precise definition of riot and civil disorder, and the election to cover many of these losses will rest in the discretion of the federal agency.

There is still another aspect of the individual company assignments which is even more undesirable. We have sought a plan which would limit the Federal Government participation to a stand-by-role, in which it is earnestly hoped the Government would never be called upon to respond for loss. The FAIR Plans, as proposed, would involve the Federal Government in virtually every riot occurrence — the net retentions for many companies under the proposed plans would be less than \$10,000.

It is hoped that the present threat of riot and civil disorder is a transitory social problem, and that it will dissipate as solutions for the underlying social problems are found. When the threat of gross man-made catastrophes has been removed, we would hope that the federal involvement in our business would also disappear.

If the federal agency does serve in a stand-by capacity, and is called upon to respond only in the event of a truly catastrophic loss, its dissolution will be facilitated. If on the other hand this federal agency is involved in virtually every riot occurrence and becomes an operating element in our industry, developing the necessary staff and facilities to play an active role in our day-to-day business, it is most unlikely that it will withdraw when the threat of gross catastrophe is removed.

I submit that there is a much better method of allocating this business equitably among companies, including reinsurers, and of limiting federal participation to the disaster relief role which was intended.

This method involves the formation of pools, and is the method already adopted by New York.

The pool arrangement, unlike individual company assignments, assures the most equitable possible distribution among companies, assures maximum utilization of industry

capacity, and provides for federal participation in an appropriate capacity and at appropriate disaster levels.

A pool arrangement facilitates equitable participation by all insurers in all of the risks insured, and proportionate sharing of expenses. It also facilitates the participation in the urban market of companies geographically removed from the urban areas, and lacking facilities there.

The pool arrangement permits full utilization of industry capacity before calling upon the Federal Government. The form of reinsurance which will be offered employs percentage of written premium as a basis of retention. When applied on an individual company basis, the retention is reached at very low levels for companies which have a relatively small written premium in the particular state. When federal reinsurance is afforded to a pool, however, the reinsurance coverage is not involved until the specified percentage of written premiums for the entire pool is reached.

Use of a pool also facilitates identification of this business for coding and statistical purposes, and for ascertaining eligibility for reinsurance coverage. Proper identification of this business is essential to the development of actual cost data and appropriate rate levels. A pool, unlike multiple policies covering each risk, will facilitate coding and analysis of amounts of insurance, concentrations of exposure, insurance-to-value, etc.

Use of a pool will minimize expenses of administration in several ways. It will avoid the necessity of issuing a number of policies on individual risks and will also eliminate multiplication of effort in administering reinsurance.

The arrangement established with regard to fire and E. C. will undoubtedly set the pattern for the extension of these facilities to burglary, plate glass, and other coverages, where individual company assignments will be even more inequitable than in the case of fire insurance.

INA made these arguments before the Hughes Panel, and throughout the legislative effort to produce a federal reinsurance plan. The federal plan does provide that the criteria for a FAIR plan, as enumerated in the statute, may be waived upon certification by an insurance commissioner that such a plan is unnecessary or inadvisable in view of local law or circumstances. It is expressly understood that a state having adopted an effective pool plan need not also have a FAIR Plan.

INA accordingly urges all commissioners to adopt a pool plan rather than an individual company placement facility, and we suggest to you as a model plan the one adopted in New York.

The federal bills require the state authority to advise the federal agency concerning the effectiveness of whatever plan is in operation, and the need to form a pool of insurers or adopt other programs to make essential property insurance more readily available. State legislation should not, in any event, preclude the formation of such pools.

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COMMISSIONER PRICE: Mr. President, I move that the full report as given on the meeting of the Executive Committee be received and adopted.

PRESIDENT BENTLEY: Is there a second to the motion?

COMMISSIONER BARNES: Second.

PRESIDENT BENTLEY: The motion has been seconded by Commissioner Barnes of Colorado. Is there conversation on this report? Is there objection to adopting it? Commissioner Mastos has suggested that the words "Executive Secretary" in the report, which amended the original report, include the words "Executive Secretary" following "Director of Research." We have attempted to make the Director of Research also the Executive Secretary, and Commissioner Mastos has moved that this report be amended by modifying the language, "Executive Secretary," to use the language, "Acting Executive Secretary." Is there a second to that motion?

COMMISSIONER BARNES. Second.

PRESIDENT BENTLEY: The motion has been made and seconded that the report be amended to stipulate the phrasing, "Acting Executive Secretary" rather than "Executive Secretary." Is there objection to the adoption of that amendment? The Chair hears no objection and the amendment is adopted.

Is there objection to the adoption of this report of the Executive Committee? The Chair hears no objection to the adoption of this report of the Executive Committee and it is hereby adopted.

Gentlemen, you are to be congratulated on the adoption of this report. It goes beyond the routine matters concerned there. It culminates a 20-year need to reorganize this Association, to give substance to it. We reduced the proposed budget by 38% this morning. We now have a realistic budget. We have established a commonsense approach to financing this Association for the next few years. We have employed new personnel; this Association is now reorganized. We are behind time but we have the necessary staff here with the necessary initiative and determination to do some catching up in the years ahead. So you are to be congratulated. We congratulate you and personally we thank you.

PRESIDENT BENTLEY: The next report to be heard is that on the Examinations Committee, to be presented by Commissioner Lee Kueckelhan of the State of Washington, who is now recognized.

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EXAMINATIONS (B) COMMITTEE

AGENDA - MTG. #36

WEDNESDAY A.M.

JUNE 19, 1968

10:30-12:00

BALLROOM B

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Reference

1968 Proc. VOL. I pp. 85-104

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1. Examinations Manual Revision (B1) Subcom. Report (Mtg. 14)
    - Hon. Richard S. L. Roddis, Chm., Calif.
    - Hon. John F. Bolton, Jr., V.Chm., Ill.
    - Refs: 1966 Proc. VOL. II p. 377 (additional references)
    - 1966 Proc. VOL. II pp. 378-383
    - 1967 Proc. VOL. I p. 80
    - 1967 Proc. VOL. II pp. 339-342
    - 1968 Proc. VOL. I p. 95
  2. Examinations of Accounts and Records compiled by Electronic Computers (B2) Subcom. Report (Mtg. 25)
    - Hon. Richard S. L. Roddis, Chm., Calif.
    - Refs: 1966 Proc. VOL. II p. 377 (additional references)
    - 1966 Proc. VOL. II pp. 383-384
    - 1967 Proc. VOL. I pp. 80-94
    - 1967 Proc. VOL. II p. 337 N.R.
    - 1968 Proc. VOL. I p. 86 N.R.
  3. To Study Compensation System of Examinations (B3) Subcom. NMS
    - Hon. Louis T. Mastos, Chm., Nev.
    - Refs: 1966 Proc. VOL. II p. 377 (additional references)
    - 1966 Proc. VOL. II p. 378 N.R.
    - 1967 Proc. VOL. I p. 72 N.R.
    - 1967 Proc. VOL. II p. 337 N.R.
    - 1968 Proc. VOL. I p. 86 N.R.
  4. Association Examinations Procedure for Rating and Statistical Organizations (B4) Subcom. Report (Mtg. 9)
    - Hon. Richard E. Stewart by Alexander E. Fox, Chm., N. Y.
    - Refs: 1947 Proc. pp. 240-242
    - 1967 Proc. VOL. I pp. 72-73
    - 1967 Proc. VOL. II p. 343
    - 1968 Proc. VOL. I pp. 97-104
  5. Current Reinsurance Practices
    - Ref: 1968 Proc. VOL. I p. 86
  6. Any other matter submitted for consideration.
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EXAMINATIONS (B) COMMITTEE Report  
(Mtg. 36)

Examinations (B) Committee met in Ballroom B of the Portland Hilton Hotel at 10:30 a.m. on Wednesday, June 19, 1968. Chairman announced that a quorum was present and Agenda Items were taken up in the following order.

The Report of the Examination Manual Revision (B1) Subcommittee was submitted by Mr. Christy P. Armstrong for Chairman Roddis of California. The Report was received and adopted without opposition in the Executive Session.

Item 2 — Examination of Accounts and Records Compiled by Electronic Computers (B2) Subcommittee did not have any items to present to us and no meeting was held.

Item 3 — To Study Compensation System of Examinations (B3) Subcommittee did not have a meeting.

Item 4 — Association Examinations Procedure for Rating and Statistical Organizations (B4) Subcommittee Report was presented by Mr. Malmuth for Superintendent Stewart of New York. This Report was received and subsequently adopted in Executive Session without opposition.

Item 5 — Current Reinsurance Practices, referred to in (B1) Subcommittee Report, did not submit any other Report.

As each Item was submitted, those present were offered an opportunity to express the views they might have on the subject and no comments were offered. No Department Member or Committee Member had any other matters for consideration and the Meeting was adjourned at 11:00 a.m.

Copies of the above referenced Reports are attached hereto.

Hon. Lee I. Kueckelhan, Chm., Wash.; Hon. C. Eugene Farnam, V.Chm., Mass.; Hon. Frank R. Montgomery, W. Va.; Hon. David M. Pack, Tenn.; Hon. John F. Bolton, Jr., Ill. by R. Williams; Hon. William G. Walton, Wyo.

Association Examinations Called and Started

December 1, 1967 through May 31, 1968

<i>Company</i>	<i>Location</i>	<i>Date Started</i>	<i>Zones &amp; States Participating</i>
<b>ALABAMA</b>			
Guaranty Savings Life Ins. Co.	Montgomery	1-2-68	3 (Ala) ; 2 SC ; 3 Ga
Liberty National Life Ins. Co.	Birmingham	5-6-68	3 (Ala) ; 2 NC ; 3 La ; 5 Okla ; 6 w
<b>ALASKA</b>			
(None)			
<b>ARIZONA</b>			
(None)			
<b>ARKANSAS</b>			
American Foundation Life Ins. Co.	Little Rock	4-29-68	5 (Ark) ; 3 Ga
Volkswagen Ins. Co. of Little Rock, Ark.	St. Louis, Mo.	4-29-68	5 (Ark) ; 1 Mass ; 2 Del ; 3 Mo ; 4 Mich ; 6 Calif
<b>CALIFORNIA</b>			
California-Western States Life Ins. Co.	Sacramento	1-2-68	6 (Calif) ; 5 Tex ; 6 Wash
Beneficial Standard Life Ins. Co.	Los Angeles	2-19-68	6 (Calif) ; 1 Mass ; 2 Del ; 3 Ga ; 4 SD
Golden State Mutual Life Ins. Co.	Los Angeles	3-4-68	6 (Calif) ; 4 w ; 5 w
Pierce National Life Ins. Co.	Los Angeles	5-13-68	6 (Calif)
Signal Ins. Co.	Los Angeles	5-29-68	6 (Calif)
<b>COLORADO</b>			
Capitol Life Ins. Co.	Denver	1-8-68	5 (Colo) ; 3 La ; 4 Ind ; 5 Wyo ; 6 Utah
Financial Assurance, Inc.	Denver	2-1-68	5 (Colo)
National Western Life Ins. Co.	Austin, Texas	4-15-68	5 (Colo) ; 4 Ind ; 4 SD ; 5 Tex ; 6 Calif
<b>CONNECTICUT</b>			
Safeguard Ins. Co. (See Royal-Globe Group)	New York, N. Y.	12-18-67	1 (Conn) ; 1 NY ; 1 NJ ; 2 WVa ; 3 Miss ; 4 Mich ; 5 Okla ; 6 Nev
Hartford Insurance Group Hartford Fire Ins. Co. Hartford Accident & Indemnity Co. Hartford Life & Accident Ins. Co.	Hartford	1-29-68	1 (Conn) ; 1 NJ ; 1 NY ; 2 Del ; 3 Miss ; 4 Minn ; 5 NM ; 6 Nev
New York Underwriters Ins. Co. (N. Y. Corp.) Citizens Ins. Co. of New Jersey (N. J. Corp.) Twin City Fire Ins. Co. (Minn. Corp.) National Fire Ins. Co. (See Continental Group)	Chicago, Ill.	4-29-68	1 (Conn) ; 1 NY ; 2 Pa ; 2 WVa ; 3 Ga ; 4 Ill ; 5 w ; 6 Nev
<b>DELAWARE</b>			
(None)			

<i>Company</i>	<i>Location</i>	<i>Date Started</i>	<i>Zones &amp; States Participating</i>
<i>DIST. OF COLUMBIA</i>			
Acacia Mutual Life Ins. Co.	Washington	1-8-68	2(DC); 1 Conn; 3 Ala; 4 Mich; 5 Okla; 6 Mont
<i>FLORIDA</i>			
(None)			
<i>GEORGIA</i>			
Coastal States Life Ins. Co.	Atlanta	1-15-68	3(Ga); 2 SC; 3 Fla
First of Georgia Ins. Co.	Augusta	5-6-68	3(Ga); 2 w
First of Georgia Life Ins. Co.			
First of Georgia Underwriters Co.			
Standard National Ins. Co.	Atlanta	5-13-68	3(Ga); 2 SC
<i>GUAM</i>			
(None)			
<i>HAWAII</i>			
(None)			
<i>IDAHO</i>			
Continental Life & Accid. Co.	Boise	4-29-68	6(Idaho)
Grange Mutual Life Ins. Co.	Nampa	5-20-68	6(Idaho)
<i>ILLINOIS</i>			
Amalgamated Labor Life Ins. Co.	Chicago	12-4-67	4(III); 3 Ga; 6 Mont
Illinois Mutual Life & Casualty Co.	Peoria	12-4-67	4(III)
Federal Life Ins. Co.	Chicago	1-2-68	4(III); 2 WVa; 6 w
Supreme Life Ins. Co. of America	Chicago	2-5-68	4(III); 2 w
Chicago Ins. Co.	Chicago	2-13-68	4(III); 3 Ga; 6 Ore
Great Central Ins. Co.	Peoria	2-26-68	4(III); 2 w; 3 Ga; 5 w; 6 Mont
Zurich American Life Ins. Co.	Chicago	3-4-68	4(III)
Prudence Mutual Casualty Co.	Chicago	3-11-68	4(III); 2 Pa; 3 Ga
Continental Casualty Co.	Chicago	4-29-68	4(III); 1 Conn; 1 NY; 2 Pa; 2 WVa; 3 Ga; 5 w; 6 Nev
Continental Assurance Co. Transportation Ins. Co.			
National Fire Ins. Co. (Conn.)			
American Casualty Co. (Pa.)			
Valley Forge Ins. Co. (Pa.)			
Valley Forge Life Ins. Co. (Pa.)			
Transcontinental Ins. Co. of New York (N. Y.)			
Fidelity Life Association	Fulton	5-20-68	4(III); 2 Del
<i>INDIANA</i>			
American Income Life Ins. Co.	Waco, Texas	1-8-68	4(Ind); 2 Del; 3 Miss; 5 ?
Consumers Nat'l Life Ins. Co.	Evansville	1-15-68	4(Ind); 5 Wyo; 6 Ariz
Midwestern United Life Ins. Co.	Fort Wayne	2-12-68	4(Ind); 2 Ohio
State Life Ins. Co.	Indianapolis	3-18-68	4(Ind); 2 Del; 3 Ga; 5 Tex; 6 w



<i>Company</i>	<i>Location</i>	<i>Date Started</i>	<i>Zones &amp; States Participating</i>
<b>IOWA</b>			
Equitable Life Ins. Co. of Iowa	Des Moines	2-6-68	4(Iowa); 1 Mass; 2 Del; 3 Ky; 5 w; 6 w
Central Life Assurance Co.	Des Moines	2-13-68	4(Iowa); 2 Del; 5 w; 6 Ore
<b>KANSAS</b>			
Pyramid Life Ins. Co.	Kansas City	4-29-68	5(Kans); 3 Ga; 4 Iowa; 6 Mont
<b>KENTUCKY</b>			
Lincoln Income Life Ins. Co.	Louisville	4-22-68	3(Ky); 5 Texas
<b>MARYLAND</b>			
Monumental Life Ins. Co.	Baltimore	2-13-68	2(Md); 2 Del; 3 Ky; 4 Mich
Sun Life Ins. Co. of America	Baltimore	2-19-68	2(Md); 1 Mass; 2 WV; 4 Mich
The Title Guarantee Co.	Baltimore	2-19-68	2(Md); 2 WV; 5 ?
Fidelity & Deposit Co. of Md.	Baltimore	5-20-68	2(Md); 1 NH; 2 Del; 3 Ga; 4 Iowa; 5 Tex; 6 w
Maryland Life Ins. Co. of Baltimore	Baltimore		
<b>MASSACHUSETTS</b>			
Berkshire Life Ins. Co.	Pittsfield	1-2-68	1(Mass); 2 WV; 3 Ga; 4 Mich
John Hancock Mutual Life Ins. Co.	Boston	1-2-68	1(Mass); 2 WV; 3 Ky; 4 SD; 5 Okla; 6 Idaho
Massachusetts Indemnity & Life Ins. Co.	Boston	3-4-68	1(Mass); 2 Del; 3 Ga; 4 w; 6 w
Worcester Mutual Fire Ins. Co. Guarantee Mutual Ins. Co. of America	Worcester	5-13-68	1(Mass); 2 Del
<b>MICHIGAN</b>			
Confederation Life Association (U. S. Business)	Toronto, Canada	2-13-68	4(Mich); 1 Conn; 2 Del; 3 Ga; 6 w
Gleaner Life Ins. Society	Birmingham	2-19-68	4(Mich); 2 w
North American Life Assur. Co. (U. S. Business)	Toronto, Canada	4-15-68	4(Mich); 2 Del; 6 Wash
The American Road Ins. Co.	Dearborn	5-27-68	4(Mich); 2 Del; 3 Ga; 5 w
<b>MINNESOTA</b>			
Northwestern National Life Ins. Co.	Minneapolis	1-17-68	4(Minn); 2 Del; 3 Ga; 5 w; 6 w
Twin City Fire Ins. Co. (See Hartford Ins. Group)	Hartford, Conn.	1-29-68	4(Minn); 1 Conn; 1 NJ; 1 NY; 2 Del; 3 Miss; 5 N.Mex; 6 Nev
Title Ins. Co. of Minnesota	Minneapolis	4-8-68	4(Minn); 3 Ga
<b>MISSISSIPPI</b>			
(None)			
<b>MISSOURI</b>			
Business Men's Assurance Co. of America	Kansas City	1-8-68	3(Mo); 2 Del; 4 Mich; 5 Colo; 6 Ariz
Atlas Mutual Ins. Co.	Kansas City	3-4-68	3(Mo); 6 w
Commercial State Life Ins. Co.	St. Louis	3-25-68	3(Mo); 4 Iowa
Travelers Protective Assoc. of America	St. Louis	5-13-68	3(Mo); 2 w; 4 Iowa

<i>Company</i>	<i>Location</i>	<i>Date Started</i>	<i>Zones &amp; States Participating</i>
<b>MONTANA</b>			
(None)			
<b>NEBRASKA</b>			
Nebraska Nat'l. Life Ins. Co.	Lincoln	2-19-68	5(Neb) ; 6 w
Mutual of Omaha	Omaha	5-20-68	5(Neb) ; 1 Vt ; 2 WV ; 3 Fla ;
United Benefit Life Ins. Co.			4 Iowa ; 6 w
<b>NEVADA</b>			
(None)			
<b>NEW HAMPSHIRE</b>			
National Grange Mut. Ins. Co.	Keene	3-18-68	1(NH) ; 2 Del ; 4 Mich
<b>NEW JERSEY</b>			
Newark Ins. Co. (See Royal Globe Group)	New York, N. Y.	12-18-67	1(NJ) ; 1 NY ; 1 Conn ; 2 WV ;
Citizens Ins. Co. of N. J. (See Hartford Ins. Group)	Hartford, Conn.	1-29-68	3 Miss ; 4 Mich ; 5 Okla ; 6 Nev ;
			1(NJ) ; 1 Conn ; 1 NY ; 2 Del ;
			3 Miss ; 4 Minn ; 5 N.Mex ;
			6 Nev
<b>NEW MEXICO</b>			
(None)			
<b>NEW YORK</b>			
The United States Life Ins. Co. in the City of New York	New York	12-4-67	1(NY) ; 2 WV ; 3 Ga ; 4 Ind ;
Royal Globe Group	New York	12-18-67	6 Ariz
American & Foreign Ins. Co.			1(NY) ; 1 Conn ; 1 NJ ; 2 WV ;
British & Foreign Marine Ins. Co. Ltd. U. S. Branch			3 Miss ; 4 Mich ; 5 Okla ; 6 Nev
Globe Indemnity Co.			
Liverpool & London & Globe Ins. Co. Ltd. U. S. Branch			
London & Lancashire Ins. Co., Ltd. U. S. Branch			
Marine Ins. Co., Ltd., U. S. Branch			
Newark Ins. Co. (N. J. Corp.)			
Queen Ins. Co. of America			
Royal Indemnity Co.			
Royal Ins. Co. Ltd. U. S. Br.			
Thames & Mersey Marine Ins. Co. Ltd., U. S. Branch			
Western Assur. Co. U. S. Br.			
New York Underwriters Ins. Co. (N. Y. Corp. See Hart- ford Ins. Group)	Hartford, Conn.	1-29-68	1(NY) ; 1 Conn ; 1 NJ ; 2 Del ;
Eagle Star Ins. Co., Ltd.	New York	2-19-68	3 Miss ; 4 Minn ; 5 N.Mex ;
General Fire & Casualty Co.	New York	3-4-68	6 Nev ;
			1(NY) ; 6 w
			1(NY) ; 2 Del ; 3 Ga ; 4 Ind ;
			6 w
American Home Assurance Co.	New York	4-8-68	1(NY) ; 2 Pa ; 3 Ky ; 4 Ind ;
The Ins. Co. of the State of Pa.			5 w ; 6 Ariz
Reliance Marine Ins. Co., Ltd.	New York	4-8-68	1(NY) ; 6 w
Union Ins. Society of Canton			
Transcontinental Ins. Co. of N. Y. (See Continental Gp.)	Chicago, Ill.	4-29-68	1(NY) ; 1 Conn ; 2 Pa ; 2 WV ;
			3 Ga ; 4 Ill ; 5 w ; 6 Nev
<b>NORTH CAROLINA</b>			
Durham Life Ins. Co.	Raleigh	1-15-68	2(NC) ; 2 Va
Pyramid Life Ins. Co.	Charlotte	3-11-68	2(NC) ; 3 Ga

<i>Company</i>	<i>Location</i>	<i>Date Started</i>	<i>Zones &amp; States Participating</i>
<b>NORTH DAKOTA</b>			
American Life & Casualty Ins. Co.	Fargo	3-19-68	4(ND) ; 6 Mont
Lincoln Mut. Life & Casualty Ins. Co.	Fargo	3-26-68	4(ND) ; 5 w
Security International Ins. Co.	Fargo	5-13-68	4(ND)
<b>OHIO</b>			
Midland Mutual Life Ins. Co.	Columbus	1-15-68	2(Ohio) ; 1 ? ; 4 Mich ; 6 Ariz
Western & Southern Life Ins. Co.	Cincinnati	1-22-68	2(Ohio) ; 3 Ky ; 4 Ind ; 5 w ; 6 Wash
<b>OKLAHOMA</b>			
Community Nat'l. Life Ins. Co.	Tulsa	2-5-68	5(Okla) ; 3 Fla ; 4 SD
Standard Life & Accident Ins. Co.	Oklahoma City	4-29-68	5(Okla) ; 3 Miss ; 4 w ; 6 Ariz
<b>OREGON</b>			
Standard Ins. Co.	Portland	1-2-68	6(Ore) ; 6 Ariz
<b>PENNSYLVANIA</b>			
Provident Mutual Life Ins. Co. of Philadelphia	Philadelphia	1-8-68	2(Pa) ; 1 Conn ; 3 Tenn ; 4 w ; 5 w ; 6 Mont.
The Ins. Co. of the State of Pennsylvania	New York (See New York)	4-8-68	2(Pa) ; 1 NY ; 3 Ky ; 4 Ind ; 5 w ; 6 Ariz
Valley Forge Ins. Co.	Chicago, Ill.	4-29-68	2(Pa) ; 1 Conn ; 1 NY ; 2 WV ; 3 Ga ; 4 Ill ; 5 w ; 6 Nev
Valley Forge Life Ins. Co. (See Continental Group, Chicago, Ill.)			
Reliance Ins. Co.	Philadelphia	4-29-68	2(Pa) ; 1 NJ ; 3 Ga ; 4 w ; 5 w ; 6 Nev
Planet Ins. Co. (Wis. Corp.)			
Pennsylvania Lumbermens Mutual Ins. Co.	Philadelphia	5-6-68	2(Pa) ; 1 NJ ; 3 Ga
<b>PUERTO RICO</b>			
(None)			
<b>RHODE ISLAND</b>			
Blackstone Mutual Ins. Co.	Providence	4-15-68	1(RI) ; 2 WV ; 3 Ga ; 4 w ; 5 w ; 6 Ariz
Firemen's Mutual Ins. Co.			
Manufacturers Mutual Fire Ins. Co.			
Affiliated F M Ins. Co.			
<b>SOUTH CAROLINA</b>			
Key Life Ins. Co. of S. C.	Columbia	3-11-68	2(SC) ; 3 Ga ; 5 w
<b>SOUTH DAKOTA</b>			
(None)			
<b>TENNESSEE</b>			
Volunteer State Life Ins. Co.	Chattanooga	3-18-68	3(Tenn) ; 2 WV ; 3 La ; 5 Tex ; 6 Utah

<i>Company</i>	<i>Location</i>	<i>Date Started</i>	<i>Zones &amp; States Participating</i>
<b>TEXAS</b>			
Girard Life Ins. Co. of America	Dallas	1-8-68	5 (Tex); 2 NC; 3 Ga; 4 Ill; 5 Colo; 6 Nev
American Bankers Ins. Co.	Waco	2-5-68	5 (Tex); 2 NC
American National Ins. Co.	Galveston	2-5-68	5 (Tex); 2 Del; 3 Ala; 4 SD; 5 Okla; 6 Nev
Great Southern Life Ins. Co.	Houston	2-5-68	5 (Tex); 3 Fla; 6 Ariz
Southland Life Ins. Co.	Dallas	2-12-68	5 (Tex); 2 WVa; 3 Ga; 6 Idaho
Millers Mutual Fire Ins. Co. of Texas	Fort Worth	4-15-68	5 (Tex); 3 Miss
Millers Casualty Ins. Co. of Texas			
Millers Life Ins. Co. of Texas			
Trinity Universal Ins. Co.	Dallas	4-15-68	5 (Tex); 2 w; 3 Ga; 4 Mich; 6 Mont
Security National Ins. Co.			
Liberty Universal Ins. Co.	Fort Worth	5-6-68	5 (Tex); 3 La
Guild Life Ins. Co. of America	Austin	5-20-68	5 (Tex); 1 ?; 2 w; 3 Ga; 4 w
<b>UTAH</b>			
Equitable Life & Cas. Ins. Co.	Salt Lake City	1-2-68	6 (Utah); 5 Colo; 6 Ore
National Farmers Union Property & Casualty Co.	Denver, Colo.	3-11-68	6 (Utah); 4 Ind; 5 Wyo; 6 Mont
Surety Life Ins. Co.	Salt Lake City	3-11-68	6 (Utah); 6 Nev
<b>VERMONT</b>			
National Life Ins. Co.	Montpelier	5-13-68	1 (Vt); 2 w; 3 Ga; 4 Iowa; 5 Okla; 6 Mont
<b>VIRGINIA</b>			
General Fidelity Life Ins. Co.	Richmond	3-4-68	2 (Va); 3 Ga
Home Beneficial Life Ins. Co.	Richmond	3-4-68	2 (Va); 3 Ga
<b>VIRGIN ISLANDS</b>			
(None)			
<b>WASHINGTON</b>			
Olympic National Life Ins. Co.	Seattle	3-25-68	6 (Wash); 6 Ore
Northern Life Ins. Co.	Seattle	4-22-68	6 (Wash); 2 Del; 6 Mont
<b>WEST VIRGINIA</b>			
Stonewall Jackson Life Ins. Co.	Huntington	12-4-67	2 (WVa); 2 Va
<b>WISCONSIN</b>			
National Mutual Benefit Planet Ins. Co.	Madison	12-11-67	4 (Wis)
	Philadelphia, Pa.	4-29-68	4 (Wis); 1 NJ; 2 Pa; 3 Ga; 5 w; 6 Nev
	(See Pennsylvania)		
Association Life Ins. Co., Inc.	Milwaukee	5-6-68	4 (Wis); 4 Iowa
<b>WYOMING</b>			
(None)			

Association Examination Calls issued, but starting date June 1, 1968 or later. These Calls will appear on next Report.

<i>Name of Company</i>	<i>Location</i>	<i>Starting Date</i>
<i>CALIFORNIA</i>		
Transport Indemnity Company	Los Angeles	6-17-68
<i>COLORADO</i>		
National Farmers Union Life Insurance Co.	Denver	6-3-68
The Educators Company for Insurance on Lives and Granting Annuities	Denver	6-26-68
<i>GEORGIA</i>		
Georgia International Life Insurance Company	Atlanta	6-10-68
<i>ILLINOIS</i>		
Polish Women's Alliance of America	Chicago	6-3-68
Unity of Czech Ladies and Men	Cicero	6-3-68
Victory Mutual Life Insurance Company	Chicago	7-8-68
<i>INDIANA</i>		
Inter-Ocean Insurance Company	Cincinnati, Ohio	6-10-68
American United Life Insurance Company	Indianapolis	6-17-68
<i>IOWA</i>		
Farmers Elevator Mutual Insurance Company	Des Moines	6-3-68
Preferred Risk Mutual Insurance Company	Des Moines	6-10-68
Midwest Mutual Insurance Company		
State Automobile and Casualty Underwriters	Des Moines	6-17-68
American Mutual Life Insurance Company	Des Moines	6-24-68
<i>MASSACHUSETTS</i>		
Quincy Mutual Fire Insurance Company	Quincy	6-3-68
Monarch Life Insurance Company	Springfield	6-17-68
<i>MINNESOTA</i>		
St. Paul Fire & Marine Insurance Company	St. Paul	6-11-68
St. Paul Mercury Insurance Company		
Western Life Insurance Company		
<i>NEW JERSEY</i>		
Mutual Benefit Life Insurance Company	Newark	6-3-68
<i>NEW YORK</i>		
Bankers Security Life Insurance Society	Washington, D. C.	6-10-68
Continental Insurance Companies Group	New York	6-24-68
Phoenix of London Group		
<i>OHIO</i>		
State Automobile Mutual Insurance Company	Columbus	6-10-68
American Druggists' Insurance Company	Cincinnati	6-17-68
Western Reserve Life Assurance Co. of Ohio	Cleveland	6-17-68
<i>OKLAHOMA</i>		
Tri-State Group	Tulsa	6-10-68
<i>SOUTH CAROLINA</i>		
Colonial Life & Accident Insurance Co.	Columbia	6-3-68
American Mutual Fire Insurance Co.	Charleston	7-1-68
Carolina American Insurance Co.		
<i>TENNESSEE</i>		
Interstate Life & Accident Insurance Co.	Chattanooga	6-24-68
Interstate Fire Insurance Co.		
<i>TEXAS</i>		
Mercantile Security Life Insurance Co.	Dallas	7-1-68
<i>VIRGINIA</i>		
Shenandoah Life Insurance Co.	Roanoke	6-17-68
<i>WEST VIRGINIA</i>		
West Virginia Life Insurance Co.	Huntington	7-1-68

## Examinations Manual Revision (B1) Subcom. Report

(Mtg. 14)

The Examinations Manual Revision (B1) Subcommittee met in Parlor C of the Hilton Hotel in Portland, Oregon, on June 17, 1968. A quorum was present.

Mr. William Conley, Life Actuary of the Michigan Insurance Department, discussed the matter of life reinsurance and read proposed instructions to be included in the Examiners' Handbook of the National Association of Insurance Commissioners.

In Executive Session the Subcommittee moved and adopted the following resolution: Resolved that: Mr. Conley's report be considered as an interim report and be accepted as such; and that his letter of May 16, 1968, and Mr. John M. Burleigh's paper, "Raising Surplus Through Portfolio Reinsurance," be attached to the report of the Subcommittee; and that Mr. Conley of Michigan be appointed as a task force of one to consult with actuaries of other insurance departments to make further study with the industries concerned; and that Mr. Conley report to the Subcommittee at the December, 1968, meeting of the NAIC.

A discussion was held concerning whether or not there was a need for clarifying the Examiners' Handbook instructions with respect to escrow funds held by insurance companies. This matter had been placed on the agenda by Ernest Meredith of the Maryland Insurance Department. The Subcommittee adopted a resolution requesting the Maryland Department to submit a specific proposal at the next meeting of the Subcommittee to be held in Los Angeles during the month of December, 1968.

There being no further business to come before the Subcommittee, the meeting was adjourned.

Hon. Richard S. L. Roddis, Chm., Calif. by Christy P. Armstrong;  
Hon. John F. Bolton, Jr., V.Chm., Ill.; Hon. William R. Cotter, Conn.;  
Hon. Dudley A. Guglielmo, La.; Hon. David J. Dykhouse, Mich.; Hon.  
Eugene P. Brown, Ohio; Hon. Clay Cotten, Texas.

STATE OF MICHIGAN — INSURANCE BUREAU

111 N. Hosmer Street — Lansing, Michigan 48913

May 16, 1968

The Honorable Richard S. L. Roddis  
Insurance Commissioner  
Department of Insurance  
107 South Broadway  
Los Angeles, California 90012

Dear Commissioner Roddis:

Re: NAIC Examinations Manual Revision Subcommittee (B1)

At the meeting of this submittee in Honolulu on December 4, 1967, I was appointed

to supervise the conducting of a study of the subject matter of life reinsurance and draft appropriate instructions to be included in the examiner's manual.

I am enclosing twelve copies of my recommendation as to what should appear in the examiner's manual.

In addition to submitting this report to you so that it may be distributed to the subcommittee and such other persons as you believe should review it, I will briefly outline what I have done and what I suggest as to future actions. I have reviewed a number of these gimmick, semi-fraudulent, surplus aid type "so-called" reinsurance agreements and have come to the conclusion that the type of contract we are seeking to find and disapprove cannot be accurately, concisely, or completely defined in either a positive or negative sense. I have, therefore, approached this problem on the basis of setting six tests. If one or more of these tests are positive, the agreement(s) should be specifically reviewed and credits disallowed or otherwise on the basis of judgments made in the review process.

I have informally discussed this approach and all of these six standards with two actuaries who are Fellows of the Society and who are independent of company affiliations and with two actuaries (also Fellows of the Society) who work for reinsurance companies. Although the reinsurance actuaries were not asked and cannot express the position of their companies, they indicated informally that the approach had merit.

Part of the reason for describing briefly my approach is to indicate that I have taken no formal action towards reviewing this project with the life insurance or reinsurance industry or with actuaries of other insurance departments.

Subject to the committee's review and approval, I suggest the following processes :

The report should be adopted with any modifications that the members of the committee suggest on the basis that it is a preliminary draft of instructions that are to be included in the examiner's handbook. They will be included on Page A 19 as a subsection of Section X, specifically labeled with a heading of the following type: "Special Requirements Relating to Certain Life Insurance Company Reinsurance Agreements." Then a committee of department actuaries should be appointed and an industry committee appointed, the latter preferably made up principally of reinsurance company actuaries. The NAIC Committee of Actuaries would be instructed to hold hearings or discussions with the industry group and make a final report and recommendation at the December meeting.

I think the industry committee should have among its members representatives of the larger reinsurance companies. If you agree with this process, I have two names that I would specifically like to recommend for the appointment to the industry committee. They are Mr. John Burleigh (FSA) of the Connecticut General Life Insurance Company and Mr. Miles Gray (FSA), Vice President and Actuary of the General Reinsurance Corporation, Greenwich, Connecticut. Mr. Burleigh is the author of the paper appearing in the Proceedings in the Conference of Actuaries in Public Practice (which paper was referred to in my report).

I am enclosing a number of copies of this letter and of the minutes of the meeting of the committee in Honolulu last December for your convenience if you wish to distribute one or both of these items to other members of the committee. I am also enclosing three copies of Mr. Burleigh's paper.

Sincerely,

LIFE AND HEALTH DIVISION

William C. Conley  
Life Actuary

#### Examinations Manual Revision (B1) Subcommittee

Instructions to be Included in NAIC Examiner's Manual Relating to the Subject of Life Reinsurance.

Reinsurance agreements which provide for the ceding of business by a life insurance company and which contain any or a combination of the following elements should be specially reviewed and examined.

1. The agreement provides for the ceding of existing business in force.
2. The agreement provides a right to cancel retroactively.
3. The agreement provides for a retroactive adjustment that has the effect of revising or nullifying the entire transaction.
4. The agreement provides for a retroactive adjustment involving a payment from the ceding company to the assuming company.
5. The mortality risk transferred to the assuming company appears to be exceedingly small in relation to the reinsurance credit (or asset) established by the ceding company.
6. For groups or classes of individual policies there is little or no retention by the ceding company (excepting substandard classes and except as to the first \$2,000 or less of face amount).

When any one or more of these conditions exist, the reinsurance agreement should be reviewed by the actuary and/or chief examiner of the state of domicile of the ceding insurer, and/or by an actuary participating in the examination or by a consulting actuary hired specifically for the purpose of reviewing the agreement. Pending such review, credit whether in the form of reduction from liabilities or in the form of an asset should be disallowed.

Inherent in the review process and in the approval or disapproval of the agreement is a considered judgment that the surplus relief effected by the reinsurance agreement is either very small in relation to the surplus of the company or is reasonable in relation to the balance sheet, operating statement, general financial situation and management plans of the company and is not solely or primarily for the purpose of:

1. Increasing apparent surplus in published financial statements,
2. Avoiding impairment of capital or liabilities.

It is further suggested that in making these judgments they be made in part, at least, by using standards such as those outlined in the paper entitled "Raising Surplus through Portfolio Reinsurance" appearing in Volume 16 of the Proceedings of the Conference of Actuaries in Public Practice. The principal applicable part of this paper is Section II which appears on Page 98 of Volume 16.

### Raising Surplus Through Portfolio Reinsurance

John M. Burleigh

Adequacy of surplus funds for continued expansion is becoming a problem for an increasing number of companies. These companies will have to find ways of increasing their surplus funds if they are to survive and continue to grow as a separate entity. There are several approaches (some of which are not permissible in all states) a life insurance company may employ towards increasing its surplus. Among these are stock issues, surplus debentures and guaranty funds (where permissible), a cut-back in operations, merging or acquiring other companies, and portfolio reinsurance. Each of these methods has its own particular advantages and disadvantages. The one best suited to any particular company depends upon many factors such as the extent and urgency of the company's surplus problem, its long-term potential and objectives, and many others.

#### I. Portfolio Reinsurance

Under portfolio reinsurance, a company reinsures a readily definable block of its retained in-force business by transferring to the reinsurer accumulated reserves at the time reinsurance is effected and subsequent premiums as they are paid. Based on his analysis of the future profitability of the business so reinsured, the reinsurer commutes and pays to the ceding company a portion of the anticipated future book profit thereby immediately increasing the surplus of the ceding company by this amount.

Future transactions are essentially the same as under a traditional coinsurance treaty arrangement. The reinsurer reimburses the ceding company for commissions, premium taxes, surrender values, and claims. In addition to these direct reimbursements, the reinsurer will also normally pay the ceding company a reinsurance renewal expense allowance toward defraying expenses of the ceding company allocable to the reinsured block. The reinsurer maintains regular policy reserves on the reinsurance in force, thereby enabling the ceding company to deduct this amount from its total reserve liability.



The reinsurance arrangement may include a recapture clause which allows the ceding company to take back the reinsurance after the business has been in force a specified period of time. For a regular coinsurance agreement, this period of time is most frequently 10 years. Under portfolio reinsurance, on the other hand, it is not uncommon to specify a longer period before recapture may be effected. By assuring the reinsurer a longer period over which he may recoup his initial surplus drain, larger surplus relief may generally be afforded the ceding company.

When recapture is effected, the reinsurance is surrendered and the policy cash values paid by the reinsurer to the ceding company. Since the ceding company after recapture must set up reserves on the recaptured business, there will be a surplus drain to the ceding company to the extent that policy reserves exceed cash values at the time of recapture. This drain (if any) has been anticipated by the reinsurer in pricing the overall arrangement and is implicitly reflected in the amount of surplus relief afforded the ceding company when the reinsurance arrangement was first entered into.

If after several years the ceding company has been able to further increase its surplus from the sale of stock or earnings on its retained business, it is quite possible that an early recapture may be desirable. This may usually be negotiated by mutual agreement between the ceding and reinsuring companies. The reinsurer will, of course, need to recoup any unamortized portion of its own surplus drain on the reinsured business and in addition is entitled to an expense, risk and profit charge.

The "price" to recapture early is generally a function of the actual experience that has emerged the length of time the business has been in force, the amount of surplus relief originally provided, and any unamortized surplus drain still remaining.

Modified coinsurance could also be employed in effecting portfolio reinsurance arrangements. The basic difference between this and previously described coinsurance lies in the reinsurer's returning reinsurance reserves to be held by the ceding company. Interest at an agreed on rate is paid by the ceding company to the reinsurer to replace the interest loss to the reinsurer by virtue of his no longer having the assets behind the reserves. Except for business reinsured at very short durations, this mode of reinsurance results in a very sizeable cash flow from the reinsurer to the ceding company. Considering the current investment climate particularly, the reinsurer will require a substantial return on assets transferred to the ceding company and hence this approach loses some of its appeal. Additionally, if there is some question that the ceding company will survive, any reinsurer will be reluctant to transfer sizeable funds.

Since surplus generated under portfolio reinsurance is essentially the commuted value of a portion of future anticipated profits on the block of business involved, surplus relief thus generated is only of a temporary nature since future additions to surplus generated by the reinsured business will be retained by the reinsurer until his surplus investment is repaid.

"Surplus" in the present context refers only to annual statement surplus which is based on a liquidating value of a company rather than the "going concern" value used, for example, in merger situations where either an exchange of stock or outright purchase is involved. Much has already been written on the problem of estimating the "going concern" value of a life insurance company and any further elaboration here is unnecessary. It should be noted, however, that the surplus relief generated through portfolio reinsurance is strictly of the "statutory" variety. Indeed on a "going concern" basis, the "surplus" of a life insurance company would be immediately reduced under portfolio reinsurance to the extent of the anticipated expense, profit, and risk charge made against future earnings by the reinsurer. Under most of the alternative approaches to raising surplus, on the other hand, "going concern surplus" would be increased by the successful application of the particular method employed.

## II. Conditions Under Which Portfolio Reinsurance is Appropriate

The reasons a company may find it necessary or desirable to increase its surplus can be grouped under the following general categories:

- A. Large increase in new business drain resulting from larger than anticipated volume of new business.
- B. Need for additional surplus for financing expansion into new markets or lines of business.
- C. The time has arrived for a previously planned increase in surplus from intentionally modest levels previously maintained and due to changed market conditions a new stock issue is not feasible.
- D. The company may wish to improve its statutory gains from operations.
- E. Poor management or outright mismanagement.

It is, of course, extremely important for the company to determine the underlying cause for the currently lower than desirable level of surplus. If, for example, poor management is the underlying cause, any addition to surplus will probably continue to be applied unproductively, and no reinsurer will be interested in providing assistance under these conditions. Similarly, if the company in the past has been operating at an intentionally low level of surplus and no basic changes in operating procedures or volume of new business are anticipated in the future, portfolio reinsurance would be inappropriate since the surplus relief so provided is temporary. In the final analysis it is necessary to treat the disease rather than the symptom.

Wherever utilization of the additional surplus generated will anticipate an immediate return of relatively substantial amounts, portfolio reinsurance becomes more appropriate. The immediate additional return from the surplus investment will partially or completely offset the reduced return on the block of business reinsured so that the total surplus will continue to remain at a satisfactory level. In the first situation listed above where the surplus depletion has been brought about by a sudden increase in new business drain, portfolio reinsurance becomes quite appropriate for consideration. The additional earnings in renewal years generated by the increased volume of retained new business will partially — or completely — offset reduced earnings on the reinsured portion of the business where the reinsurer is applying most of these earnings on the reinsured block to amortize his own surplus investment in the business.

Similarly, if a company is considering a rapid expansion of its market, portfolio reinsurance of a portion of its retained in-force business might well be appropriate for generating the necessary additional surplus for financing this expansion.

### III. Types of Business That are Appropriate for Portfolio Reinsurance

It is most desirable, of course, to minimize the amount of business which a company must reinsure to obtain the desired degree of surplus relief. Since any surplus relief is directly a function of the anticipated profitability of the business being ceded, it naturally follows that the business to be ceded should be soundly priced with realistic anticipated profit margins at all ages and plans involved. Any marginal or "loss leader" categories of business will generate little if any immediate surplus relief and any such relief that might be generated would require ceding an inordinate amount of the business in force.

Since the relief provided by portfolio reinsurance is only temporary, to whatever extent the choice of business to be ceded can maximize the period of relief, such choice is desirable, all other things being equal. Hence, for a given level of anticipated profit margin per \$1000 of in-force, permanent insurance coverage with a long premium paying period will in general generate the largest relative amount of surplus relief. By its very nature, term insurance in general will not generate surplus relief for any lasting period of time and beyond this, under current competitive pressures being brought on term insurance pricing, anticipated profit margins are oftentimes small and not infrequently non-existent.

For the older company, particularly, there will be a rather large choice as to duration of in-force business for which portfolio reinsurance may be considered. While theoretical considerations here would again suggest reinsuring business at those durations which generate the largest relative surplus relief, practical considerations of minimizing the transfer of cash in either direction between the ceding and reinsuring company also must be taken into account. Sudden large transfers of cash in either direction might cause the ceding company problems in either liquidating a portion of their current assets or quickly finding suitable investments for the funds, depending on which direction cash flows. Assuming the desirability of maximizing surplus relief while minimizing cash transfers, it will generally work out for any normal distribution of permanent insurance being ceded, that picking business between one and four years old will be quite satisfactory. As will be illustrated later, when compared with asset shares the redundancy in statutory reserves is largest at the very short durations. Under the pricing mechanism employed in determining financial adjustments upon portfolio reinsurance, this redundancy in the statutory reserve is immediately released. Also, at these shorter durations, outstanding statutory reserves which are transferred to the reinsurer are more nearly equal to the "price" the reinsurer is willing to pay for the business and hence cash flow between the companies is minimized.

Whatever block of business is chosen it should be a readily identifiable section for which all necessary separate accounting records are relatively easily maintained. Issues of specified calendar years on specified plans of insurance are most commonly the identifying criteria. It is critically important to the success of the scheme that expenses for both the ceding company and reinsurer be kept at a minimum. To this end it is quite common to avoid maintaining separate reinsurance records on each individual life by reporting all reinsurance transactions on a portfolio basis directly from the ceding company's direct premium billing and accounting machinery.

## IV. Financial Analysis

A traditional asset share analysis assists in examining both the nature of the surplus relief provided under portfolio reinsurance and the "value" of business on the books at various durations. Using the assumptions in Table I (A), asset shares, cash values, and terminal reserves per \$1000 of originally issued insurance are shown in Table I (B). These examples are illustrative only and actual results in a practical application will vary widely of course, depending on the pricing structure and underlying assumptions.

Let us define the "value" of business in force for any given duration as the present value of future additions to surplus over the next following ten years assuming surrender at the end of this period. Since the policy reserve has already been accumulated partly out of surplus in the past, any excess of the reserve over the asset share at the beginning of the ten-year period also represents a portion of the present value of future book margins. Hence, for any business in force at duration "n" the "value" of the business per \$1000 currently in force may be expressed as:

$$\left[ nV_x \cdot l_n - AS_n + \left\{ AS_{n+10} - CV_{n+10} \cdot l_{n+10} \right\} v^{10} \right] \cdot l_n$$

where:

$$nV_x = \text{nth year terminal reserve per \$1000}$$

$$AS_n = \text{nth year asset share per \$1000 original issue}$$

$$l_n = \text{portion of original lives at issue persisting n years}$$

$$CV_{n+10} = \text{(n+10)th cash value per \$1000}$$

$$v = \text{discount at asset share interest rate}$$

Using the indicated values in Table I (B) and applying the above formula, "values" of surviving business in force at various durations are derived in Table II. For issue age 40, for example, the Table II indicated total "value" of \$31.94 for business in force at the beginning of its 6th year (i.e., end of 5th year) is:

$$\text{"Reserve Excess"} = \frac{5V_{40} \cdot l_{40+5} - AS_5}{l_{40+5}} = \frac{44.98 - 37.97}{.6218} = 11.24$$

$$\text{"Future Margins"} = \frac{(AS_{15} - CV_{15} \cdot l_{40+15}) v^{10}}{l_{40+5}} = \frac{(120.17 - 101.12)(.6756)}{.6218} = 20.70$$

The large increase between years one and two reflects, of course, the unamortized new business drain which future book profits will recoup. Also beyond the second duration, values increase mainly because the difference between the asset share and cash value increases with duration. Since in this example the asset share quite quickly exceeds the cash value, the increase in "value" by duration is affected only slightly by measuring it from a point in time beyond the early heavy lapse durations. The results in Table II are obviously very sensitive to both the reserve and the cash value basis employed in measuring book profits. A change from CRVM to net level reserves for example would substantially increase indicated values by considerably increasing the new business drain. (The ultimate profitability of the business, of course, is not affected by the reserve basis chosen.) Similarly, if larger than minimum cash values are employed, the indicated values would be substantially reduced since we have chosen surrender of the policy at the end of ten years for measuring book profits. (As will be indicated shortly, however, this is a convenient assumption for translating these results to reflect the impact of portfolio reinsurance with a ten-year recapture clause.)

Turning to portfolio reinsurance, if we consider that reserves on outstanding business are paid to the reinsurer together with future renewal premiums, and in addition assume that the reinsurer's expense allowances are the same as the expense assumptions entering Table I (B) asset shares, it becomes apparent that the values in Table II

are identically equal to the value of the business to the reinsurer before his expense, risk, and profit deductions. The surplus relief that could be provided by the reinsurer would be less than the indicated amount by the present value of the reinsurer's deductions for expense, risk and profit.

One approach to setting a reinsurance value on business would be for the reinsurer to immediately release the "reserve excess" and deduct his future expense, risk, and profit margin from the remaining present value of the total margins. Applying this approach to business in force at the beginning of the second, third, or fourth years, a reinsurer might be willing to provide surplus relief of \$15, \$20, and \$35 for each \$1000 of insurance in force for issue ages 25, 40, and 55 respectively. Using these figures, Table III analyzes the relative surplus position before and after 100% portfolio reinsurance. From Table I (B) surplus at the end of each year per \$1000 of original issue is derived as merely the difference between the asset share and policy reserve. Since the indicated surplus is per \$1000 of original issue and our illustrative surplus relief values of \$15, \$20, and \$35 are per \$1000 of current in force, these latter values have been translated in Section (B) of Table III to an equivalent basis per \$1000 of original issue by applying appropriate persistency factors from Table I (B). For example, the \$15.42 for age 40 for business in force at the end of two years as being equivalent to \$20 per \$1000 of current in force is merely \$20 times .7712. Surplus after reinsurance in Section (C) is merely surplus before reinsurance from Section (A) increased by generated surplus relief in Section (B).

If reinsurance expense allowances are equal to the expense assumptions in the asset shares which in turn are equal to the actual expenses of the ceding company assessed against the reinsured block and interest is ignored, there will be no further change in surplus arising from the business reinsured once the relief has been obtained. By examining the progression of surplus figures before reinsurance in Part (A) of Table III and noting the last year for which this surplus is less than the surplus after reinsurance in Part (C), the approximate period of years for which surplus is relieved is readily determined. Part (D) shows the results thus determined. For issue age 55 business at its second duration, for example, the surplus after reinsurance is \$7.85 per \$1000 of original issue. From Section (A) of Table III it can be seen that the last year for which the surplus without reinsurance is less than this is the ninth duration (i.e., \$6.96). Hence, for this particular issue age and duration, the period over which surplus relief is provided runs from the second through ninth durations or seven years as indicated in Section (D). The period of time over which surplus relief is provided will vary widely depending on plan of insurance, pricing, and cash value and reserve bases. While the example is illustrative and reasonable under the imposed assumptions, it should not necessarily be considered typical.

#### V. Administrative Handling

Once the block of retained insurance in force which is to be considered for portfolio reinsurance has been identified, the reinsurer will need precisely the same data as is required for determining expense allowances on traditional coinsurance. This will include premium rates, commission schedules, cash values and reserves for the plans of insurance to be reinsured. In addition, a distribution of retained insurance in force by plan, age and year of issue will be necessary. This data may be generally readily obtained from the ceding company's valuation file, in which case a duplicate copy of the appropriate portion of the file may be sent to the reinsurer who will analyze and break it down into the appropriate segments. In addition, the reinsurer will want a copy of the ceding company's underwriting rules and perhaps several years' annual statements in order to better assess the anticipated profitability of the business proposed for reinsurance. The portion of the business written on a non-medical basis will be considered as will any "guaranteed issue", "franchise", or any other such types of business. The reinsurer may likely ask to review the underwriting on a sample of the individual cases in force. After reviewing data and estimating anticipated profit margins in the business, the reinsurer will make an offer to reinsure a specified portion of the defined in-force block with an attendant, specific surplus relief evolving.

The portion to be reinsured will generally be varied to provide the specific amount of surplus relief required. In the interest of administrative simplicity, Disability and Accidental Death Benefits are commonly excluded from portfolio reinsurance as are paid-up and extended insurance in force at the time reinsurance is ceded. However, if the accounting mechanisms of the ceding company readily permit breaking out all necessary data on these coverages for the block of insurance involved, there is no reason not to include them also in the reinsurance arrangement.

Before consummating any reinsurance arrangement, the ceding company should ascertain that no statutory restrictions exist which prohibit or qualify the arrangement. Several states have statutes limiting the ability of a company to cede a major portion of a given risk or a major portion of its in-force business to another company. In many

cases these statutes are not clear as to whether or not they apply to portfolio reinsurance in the sense discussed here or reinsurance through the certificate of assumption route which has many of the aspects of an outright acquisition. Ohio, for example, requires domestic companies to obtain written approval before ceding more than 4/5 of any given risk. Similarly, Illinois requires specific approval for domestic companies to enter into any reinsurance agreements "other than agreements made in the ordinary course of business covering reinsurance of individual lives under reinsurance agreements relating to current business." Idaho requires specific approval for domestic companies to reinsure "all . . . or substantially all of a major class . . . (of business) with another insurer, stock or mutual, by an agreement of bulk reinsurance." Several states require filing of the reinsurance treaty as a prerequisite to approval of the arrangement.

Once basic agreement has been reached on the terms of the portfolio reinsurance, a formal treaty is drafted for further consideration by the ceding company. Normally included in this document is a detailed listing on a policy-by-policy basis of the insurance to be covered under the portfolio reinsurance arrangement. If this material has not been previously submitted in conjunction with the initial pricing of the reinsurance arrangement, it is necessary at this time that the ceding company provide the reinsurer with these details of the block to be covered.

While it is convenient for the reinsurance to become effective on December 31 of a given year in order that normal annual statement accounting may be employed in determining the financial transactions between the companies, there is no reason that the reinsurance arrangement cannot become effective on some interim date provided the ceding company has the machinery necessary for determining reserves on the current in-force and gross and net deferred and outstanding premiums as of the particular date of assumption by the reinsurer. Assuming portfolio reinsurance becomes effective on a December 31, annual statement accounting entries resulting from this transaction would evolve as follows based on the following assumed data :

A. Amount of reinsurance to be ceded	=	\$10,000,000
B. Surplus relief to be provided by reinsurer @ \$20 per \$1000	= \$	200,000
C. December 31 mean reserves @ \$25 per \$1000	= \$	250,000
D. Net deferred and outstanding premiums	= \$	25,000

Under the above assumptions trial balance accounting entries would appear as follows:

Account	Debit	Credit
Reserves Transferred to Reinsurer	\$250,000	
Reinsurance Expense Allowance		\$200,000
Cash		50,000
	<u>\$250,000</u>	<u>\$250,000</u>

It is not uncommon to account for the reserve transfer item as negative renewal premium but on the other hand, if this seems to grossly distort a company's annual statement, it probably is preferable to break it out as a "write-in" line in the statement. Similarly, annual statement instructions call for reinsurance expense allowances to be included as a negative item in Exhibit 5 expenses. However, again, if this would otherwise distort figures, it also could be included as a "write-in" line.

Since the reinsurer's pricing is based on either terminal or mean reserves which presuppose payment of the annual premium in full, the net surplus relief provided by portfolio reinsurance is equal to the reinsurer's quoted "price" less net deferred and outstanding premiums as of the date of assumption. Again, under the preceding assumptions, the effect on assets and liabilities of the ceding company resulting from portfolio reinsurance would be as follows:

	Assets	Liabilities	Surplus
Cash	-\$50,000		-\$ 50,000
Net Deferred and Outstanding Premium	-\$25,000		-\$ 25,000
Policy Reserves		-\$250,000	+\$250,000
Total	<u>-\$75,000</u>	<u>-\$250,000</u>	<u>+\$175,000</u>

The above suggested accounting treatment infers that the surplus relief will go through the gain and loss exhibit. This is probably the more common approach to handling

the transaction under the thesis that accumulated reserves transferred to the reinsurer are in the nature of a reinsurance premium and that the surplus relief afforded is a reinsurance commission and allowance on this amount. On the other hand, under the thesis that the surplus relief represents commutation of a portion of future anticipated profits, a case can be made for putting the additional increase in surplus over the amount which would have evolved on the block of business had no reinsurance occurred through the surplus account so that the gain from operations is unaffected in the year of reinsurance. Whichever view is taken, when and if recapture is effected, the reverse accounting should be handled consistently with the approach used initially.

Once agreement has been reached and a formal treaty executed, routine administration of the reinsurance is kept as simple as possible. As previously indicated, the cash transactions are reported usually monthly to the reinsurer and break down the net cash flow between all accounting entries (e.g., first premiums, renewal premiums, commissions, reinsurance allowances, premium tax, reimbursement, dividends (if applicable), surrender values, claims, claim expenses, etc.). In addition to the previous cash accounting, appropriate policy exhibit data are also reported, perhaps in a condensed form, for interim monthly reporting. Assuming the reinsurer has obtained a detailed listing usually in the form of a duplicate set of punched cards from the ceding company's valuation records, additional punched cards or other form of individual notification is sent in for terminations, claims, and changes.

For annual statement preparation, the ceding company must be able to determine all cash, asset, and liability data for the reinsured block in order that appropriate reinsurance ceded credits may be established. To maintain consistency between the companies, the ceding company should supply the reinsurer with all liabilities and assets including liabilities for claims, surrender values, commissions, dividends (if applicable) and policy reserves unless the reinsurer has been previously provided with sufficient data for determining this item from his own records. On the asset side, gross and net deferred and outstanding premiums are the major item. (Parenthetically it perhaps should be pointed out that even when the modified coinsurance mode of reinsurance is employed, the ceding company must deduct from its assets net deferred and outstanding premiums on reinsurance assumed. A fallacious line of reasoning can perhaps rather easily lead one to believe that under modified coinsurance where the ceding company is in fact holding the entire reserves on the reinsured business that it should be entitled to the net D&O assets. The fact of the matter is, of course, that the reserves transferred by the reinsurer to the ceding company presupposed payment of the full annual premium and hence any deficiency in this latter item is rightfully taken by the reinsurer as an asset with a corresponding offset to assets by the ceding company.)

#### VI. Conclusion

Portfolio reinsurance is a convenient and relatively simple means for raising surplus for limited periods of time. A prime requisite for the success of the venture is that the surplus raised become immediately productive to the extent that future surplus is not reduced below that which would have developed had no portfolio reinsurance been made effective. To provide significant amounts of surplus relief the business to the reinsured under a portfolio arrangement should be soundly priced with realistic anticipated profit margins for all ages and plans of insurance involved.

Annual statement gains arising from the first year of portfolio reinsurance may be used to offset a loss from operations otherwise emerging or further increase a previously established gain from operations.

Since the negotiations involved in consummating a portfolio reinsurance arrangement are basically actuarial in nature and statutory or regulatory restrictions are nominal, a minimum number of interested parties are involved with the result that the time and expense involved in raising the additional surplus are relatively small.

TABLE I (A)

## Asset Share, Cash Value, and Reserve Assumptions Used in Table I (B)

Plan of Insurance:	Ordinary Life, Non-Participating		
Average Size Issue:	\$10,000		
Gross Premiums Per \$1000:	Age	Premium	
	25	\$13.00	
	40	23.00	
	55	42.00	
Commissions:	1st Year	2-10	11 & After
	65%	5%	2%
Premium Taxes:	2% All Years		
Overhead Expenses:	1st Year	Renewal	
	\$50 Per Policy	\$10 Per Policy	
	65% of 1st Commission		
	25% of Premium		
Mortality:	1955-1960 Inter-Company, 15-Year Select and Ultimate		
Interest:	4%		
Lapse:	1½ x Linton "A"		
Cash Values:	1958 CSO 3% minimums		
Terminal Reserves:	1958 CSO 3% CRVM		

TABLE I (B)

## Asset Shares, Cash Values, and Reserves Per \$1,000 Issue

End of Year	Number of Persisting Share	A G E 2 5			Number Persisting	A G E 4 0		
		Asset Share	Cash Value	Reserve		Asset Share	Cash Value	Reserve
1	.8495	-10.43	-0	-0	.8489	-14.70	-0	-0
2	.7725	-1.64	-0	7.79	.7712	1.14	1.20	13.62
3	.7140	6.42	1.96	14.61	.7119	14.79	14.10	25.34
4	.6663	13.68	9.07	20.74	.6633	26.93	25.41	35.70
5	.6258	20.37	15.50	26.35	.6218	37.97	35.51	44.96
6	.5916	26.64	21.44	31.57	.5864	48.11	44.65	53.38
7	.5627	32.64	27.02	36.55	.5562	57.65	53.08	61.20
8	.5377	38.43	32.34	41.32	.5299	66.72	60.91	68.47
9	.5154	44.03	37.41	45.90	.5062	75.33	68.16	75.22
10	.4955	49.49	42.29	50.34	.4847	83.52	74.91	81.52
15	.4156	75.88	63.87	70.12	.3950	120.17	101.12	105.86
20	.3521	99.41	80.37	85.20	.3171	144.52	113.76	117.04

## A G E 5 5

End of Year	Number Persisting	Asset Share	Cash Value	Reserve
1	.8468	-24.07	-0	-0
2	.7663	2.83	9.07	21.80
3	.7035	25.04	23.68	40.03
4	.6512	44.24	45.37	55.56
5	.6061	61.41	59.69	68.88
6	.5667	76.56	72.07	80.39
7	.5320	89.93	82.85	90.41
8	.5013	102.23	92.25	99.13
9	.4731	113.59	100.36	106.63
10	.4470	123.86	107.25	112.96
15	.3307	160.50	123.02	126.51
20	.2195	161.23	107.53	109.41

TABLE II  
Maximum Value Per \$1,000 of Persisting Business In Force  
By Duration In Force

Beginning of Year	A G E 2 5			A G E 4 0		
	(1) Reserve Excess	(2) Future Margins	(3) Total (1)+(2)	(1) Reserve Excess	(2) Future Margins	(3) Total (1)+(2)
1	—0—	4.86	4.86	—0—	5.82	5.82
2	12.28	6.40	18.68	17.32	8.34	25.66
3	12.21	7.82	20.03	16.18	10.92	27.10
4	11.47	9.33	20.80	14.82	13.82	28.64
5	10.60	11.08	21.68	13.22	16.94	30.16
6	9.56	12.96	22.52	11.24	20.70	31.94
7	8.33	15.14	23.47	8.99	24.39	33.38
8	6.95	17.51	24.46	6.38	28.44	34.82
9	5.37	20.11	25.48	3.30	32.83	36.13
10	3.63	22.94	26.57	-.22	37.65	37.43

A G E 5 5			
Beginning of Year	(1) Reserve Excess	(2) Future Margins	(3) Total (1)+(2)
1	—0—	11.22	11.22
2	28.43	16.55	44.98
3	24.76	21.98	46.74
4	21.31	27.97	49.28
5	17.38	34.51	51.89
6	12.33	41.78	54.11
7	6.76	48.21	54.97
8	.90	55.33	56.23
9	- 6.18	63.15	56.97
10	-14.71	71.77	57.06

“Reserve Excess” — Excess of Reserve Over Asset Share

“Future Margins” — Present Value Over Next Following 10 Years of Risk. Contingency and Profit Margins Assuming All Business Surrenders For Its Cash Value at the End of 10 Years.



TABLE III

Surplus With and Without Portfolio Reinsurance  
Per \$1,000 Issue and Period of  
Time for Which Portfolio Reinsurance  
Provides Surplus Relief

## (A) Surplus Without Reinsurance

End of Year	I S S U E A G E		
	25	40	55
1	\$-10.43	\$-14.70	\$-24.07
2	- 9.43	-12.48	-18.97
3	- 8.19	-10.55	-14.99
4	- 7.06	- 8.77	-11.32
5	- 5.98	- 6.99	- 7.47
6	- 4.93	- 5.27	- 3.83
7	- 3.91	- 3.55	- .48
8	- 2.89	- 1.75	3.10
9	- 1.87	.11	6.96
10	- .85	2.00	10.90
15	5.76	14.31	33.99
20	14.21	27.48	51.82

## (B) Surplus Relief Provided by Reinsurance

Per M In Force @ End of 1, 2, or 3 Years:	\$15.00	\$20.00	\$35.00
Per M Originally Issued:			
1 yr. ago	12.74	16.98	29.64
2 yrs. ago	11.59	15.42	26.82
3 yrs. ago	10.71	14.24	24.62

## (C) Surplus After 100% Reinsurance

If Business Reinsured @ Duration:			
1	2.31	2.28	5.57
2	2.16	2.94	7.85
3	2.52	3.69	9.63

## (D) Period of Surplus Relief Provided by Reinsurance

If Business Reinsured @ Duration:			
1	11 yrs.	9 yrs.	7 yrs.
2	10 yrs.	8 yrs.	7 yrs.
3	9 yrs.	7 yrs.	6 yrs.

Association Examination Procedures for Rating & Statistical  
Organizations (B4) Subcom. Report  
(Mtg. 9)

The Subcommittee on Examination Procedures for Rating and Statistical Organizations met on June 17, 1968, in Parlor C of the Portland Hilton Hotel. A quorum was present.

The Chairman stated that written views (attached) had been received from the Insurance Supervisory Officials of 24 States.

Further discussion was solicited, but none was forthcoming from members of the industry.

In Executive Session, the issues involved were the subject of lengthy discussion by representatives of the various insurance departments that were represented.

There was a division of opinion as to the degree of flexibility desirable with respect to the participation in examinations of rating and advisory organizations. Two of the members of the Subcommittee stated that they would require further time for study and consultation with other insurance departments. Accordingly, upon motion made and seconded, it was voted that the matter be deferred until the December, 1968 meeting of the NAIC.

Hon. Richard E. Stewart, Chm., N. Y. by Alexander E. Fox; Hon. Richard S. L. Roddis, Calif. by Mark Kai-Kee; Hon. William R. Cotter, Conn. by Robert A. Brian; Hon. Broward Williams, Fla.; Hon. John F. Bolton, Jr., Ill. by Phil Williams; Hon. Robert D. Haase, Wisc. by Martin F. Raynoha.

STATE OF ALABAMA  
DEPARTMENT OF INSURANCE

Montgomery, Ala. 36104

February 12, 1968

Honorable Richard E. Stewart  
Superintendent of Insurance  
Insurance Department  
123 William Street  
New York, New York 10038

Association Examination Procedures for  
Rating and Statistical Organizations (B4)

Dear Superintendent Stewart:

In reply to your inquiry of February 1, 1968, it is our recommendation that examinations of statistical and rating organizations follow the Zone examination procedure and steps be taken to establish the most economical and efficient methods of examining these type organizations at least once every five years.

It is also our suggestion that when an examination is called at the discretion of the domiciliary state Commissioner that a minimum of thirty days' notice be given to the Chairman of all Zones involved. A reasonable advance notice will permit each Zone to make available the most qualified person within that Zone to participate in the examination.

Also, I concur in Mr. Cahill's suggestion that the domiciliary state Commissioner shall give notice to all states involved of the names of the states participating in the examination and invite requests on items to be examined, and recommend that this suggestion be incorporated in the examination scheduling procedures.

Yours very truly,

WALTER S. HOUSEAL  
Superintendent of Insurance

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STATE OF CALIFORNIA  
DEPARTMENT OF INSURANCE  
107 South Broadway, Los Angeles 90012

May 3, 1968

Honorable Richard E. Stewart  
Chairman, Subcommittee on Examinations  
Procedure for Rating and Statistical  
Organizations (B4)  
Superintendent of Insurance  
State of New York Insurance Department  
123 William Street  
New York, New York 10038

Dear Mr. Stewart:

Please accept my apology for the delay in answering your February 1, 1968, request for information. The responsibility for the delay is solely mine.

We have the following comments:

In determining a proper examination procedure the following points would appear to be pertinent:

(1) A major problem will be the limited availability of examination personnel with the training and experience in rating and rate making matters necessary for examination of these types of organizations.

(2) There is a great deal of variation in the scope and extent of operations of different rating and advisory organizations, with the operations of some organizations having an impact upon a broad segment of the insurance industry on a nationwide basis while other organizations operate on a much more restricted basis under limited budgets.

In view of the above, a uniform program of regular periodic association examination of all rating, advisory and statistical organizations might result in inefficient and uneconomic use of available personnel as well as excessive examination costs to some of the smaller organizations. A somewhat more flexible program permitting some exercise of discretion as to the timing of examinations and representation thereon might be preferable. It is therefore suggested that the present procedure under which the home state commissioner calls the examination and exercises certain discretionary authority be continued, subject to certain modifications. The following procedure is suggested for advisory and statistical organizations:

(1) The domiciliary state commissioner shall decide the timing of the examinations, issue the necessary calls, and exercise supervision over conduct of the examination of each association within its jurisdiction.

(2) The domiciliary state commissioner shall give notice of the impending examination to other states involved.

(3) Interested states would be invited to state their desire to participate in the examination and to submit requests on items to be covered.

(4) The domiciliary state commissioner shall exercise discretion in deciding the necessary number of participants and the jurisdictions from which they shall be invited after giving consideration to the requests submitted by other states as well as the scope of operation of the organization involved.

(5) Where the domiciliary state commissioner has not scheduled an examination of a particular organization for a period of at least five years and for any reason is unwilling or unable to proceed with a current examination, the Chairman of the Committee on Examinations of the NAIC, at the request of one or more states in which the organization is authorized to conduct operations, shall designate the supervisory official of one of such interested states to proceed with an examination in the manner described above.

The same procedure would be followed in the case of a rating organization except that in deciding the timing of the examination the domiciliary state commissioner would observe general statutory requirements that an examination shall be made at least once every five years, and step (5) above would be eliminated.

While the above program would be generally satisfactory for California, the following factors are peculiar to our State under the California Rating Law. Under the no filing type of rating law, which is in effect, the examination procedure provides the principal means of rate review whereas in a state operating under a state filing and prior approval law the insurance department is able to examine rates and rate making procedures at the time of filing. Consequently, even if an examination procedure providing for a broad zone representation is adopted, it may still be necessary from time to time, although the occasions will not be frequent, for a state operating the no filing procedure to conduct a separate examination of a particular organization in order to secure necessary rating details relating to the particular state.

A second point is that the California Rating Law provides that reports covering examinations under that law shall be confidential unless the Insurance Commissioner deems it necessary to make the report public. This has been no bar to participation by California in examinations called by other states. However, because of this provision the California Department has not invited other states to participate in examinations of California domiciled rating and advisory organizations called by the California Department. At the present time there is only one rating organization, the Pacific Fire Rating Bureau, domiciled in California which comes under the provisions of the general property and casualty rating laws. Although the PRFB operates in seven states in Zone 6, it has been possible up to this time for these states to satisfy their examination requirements without resorting to association examinations and without unnecessary duplication of examination efforts.

Very truly yours,

HARRY O. MILLER

Chief Deputy  
Insurance Commissioner

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STATE OF COLORADO  
OFFICE OF THE COMMISSIONER OF INSURANCE  
STATE OFFICE BUILDING  
DENVER 80203

March 6, 1968

The Honorable Richard E. Stewart  
Superintendent of Insurance  
123 William Street  
New York, New York 10038

Re: Examination Procedures for Rating  
and Statistical Organizations (B4)

Dear Dick:

We have long been concerned about the examination procedures for rating and statistical organizations. Colorado Statute provides that we examine any of these organizations doing business in the State at least once every five years. We have implemented this in the past by examining their local office, because of lack of facility

to conduct convention examinations on a larger scale basis. Now that there has been so much consolidation of rating organizations, the problem becomes even more involved because there actually are very few items we can really check in the local office.

It is our recommendation that an examination of rating organizations and statistical organizations be handled just the same as they are for companies. In other words, the examination should be called by the supervisory authority in the State where the principal office is domiciled. All other states would then be invited to participate in the examination and then a report should be filled out as a convention report.

Sincerely,  
J. RICHARD BARNES, C.L.U.  
Commissioner of Insurance

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STATE OF CONNECTICUT  
INSURANCE DEPARTMENT

State Office Building — Hartford, Connecticut 06115

March 14, 1968

Honorable Richard E. Stewart  
Superintendent of Insurance  
State of New York Insurance Department  
123 William Street  
New York, New York 10038

Re: February 1, 1968 request for submission of views as to whether examination of Rating and Statistical organizations on a Zone basis would be preferable, or if the calling of examinations at the discretion of the Commissioner of the domiciliary state might be satisfactory.

Dear Sir:

This Department feels that the calling of examinations of Rating and Statistical organizations at the discretion of the Commissioner of the domiciliary state is working satisfactorily. The need for change to a more formal Zone basis of examination is not apparent.

The current regulatory systems concerning rating and statistical organizations appear to be adequate. Examinations are conducted regularly and reports are distributed to the Commissioners. In addition, the rates, rating plans, and statistical plans used by the organizations are subject to review and approval by all states on an individual basis.

Suggestions concerning the improvement of current examination procedures should be reviewed and implemented if found to be constructive. As members of the committee we are happy to work toward that end.

Yours very truly,  
William R. Cotter  
Insurance Commissioner  
By: Robert A. Brian  
Actuary

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OFFICE OF COMPTROLLER GENERAL

STATE CAPITOL

Atlanta, Georgia 30334

March 6, 1968

Honorable Richard E. Stewart  
 Chairman, Subcommittee on  
 Examination Procedures for  
 Rating and Statistical Organizations (B4)  
 State of New York  
 123 William Street  
 New York, New York 10038

Dear Mr. Stewart:

Re: Your Letter of February 1, 1968

It is the feeling in this Department that examinations should be governed by the rules applying to company examinations. The determination should be made between a Zone examination or one called at the discretion of the Commissioner of the domiciliary state on the basis of the organization's spread of influence in more than one state.

Sincerely yours,

James L. Bentley  
 Insurance Commissioner

By: H. B. Sturtevant, Actuary

STATE OF ILLINOIS  
 DEPARTMENT OF INSURANCE  
 SPRINGFIELD

March 7, 1968

Reply to

Room 1600, 160 North LaSalle Street  
 Chicago, Illinois 60601  
 Telephone 346-2000  
 LD 312

Honorable Richard E. Stewart  
 Superintendent of Insurance  
 New York Insurance Department  
 123 William Street  
 New York, New York 10038

Re: Report of Subcommittee on Examination Procedures  
 for Rating and Statistical Organizations (B4)

Dear Superintendent Stewart:

Thank you for the enclosures which were received on February 21, 1968 from your Mr. Alexander E. Fox. Director Bolton requested that I determine the sentiment in our Department regarding subject matter and reply to your letter of February 1, 1968. I am enclosing a Xerox copy of a memorandum dated February 26, 1968 and prepared by our Rating Supervisor, Mr. Phil M. Williams, which memo expresses the views of this Department regarding examinations of rating and statistical organizations.

Basically, we believe the term "examination" is a misnomer, as actually Departments are interested in the statistical and rate making procedures and not in the financial condition of these organizations. Thus, the method of processing the "call" is not of primary interest to us, whether it is on a Zone basis or simply called by the domiciliary state. Briefly, we feel:

1. That the examinations should be called in a manner which incurs the least expense to the organizations involved since they actually are simply service organizations representing groups of companies.
2. That it is the responsibility of the companies in the group to maintain a solvent organization and to audit same for fiscal control purposes and that this is not a

matter of concern to the public. Therefore, we do not feel that an examination, as such, is necessary, but that an audit by a certified public accounting firm is acceptable.

3. That the normal insurance examiner has little or no background in rating matters and that the work in connection with such "examinations" should be made by rating technicians and the study should consist of a review and analysis of rate making.
4. That the domiciliary state should call the "examination" and conduct same and perhaps invite one or two other states to participate, said states sending rating technicians who will represent all the other states serviced by the organization.

Very truly yours,

JOHN F. BOLTON, JR.  
Director of Insurance

By: DONALD KARNES  
Chief Examiner

DEPARTMENT OF INSURANCE

Inter-Office Correspondence

To: -----

Date: February 26, 1968

From: Mr. Phil M. Williams

Subject: Subcommittee on Examination for  
Rating & Statistical Organizations  
(B4)

Copies:

In accordance with your request while in our office on February 26, 1968 the writer has examined the material furnished you by the above captioned NAIC Subcommittee.

The following are the writer's impressions of the possible position which our Department might wish to take regarding this subject.

1. While Zone examinations may be preferable to the rating bureaus and advisory organizations they can create certain difficulties with respect to the consolidation of efforts by Insurance Departments in the various Zones which might be involved in an examination. You are acquainted with the problems which we have encountered in the past with respect to cooperation and wholehearted effort in performing examinations on a Zone basis. Insofar as Illinois is concerned, it should only be interested in the statistical and rate making procedures of the bureau or advisory organization being examined. In many cases some states wish to examine all the statistical data and rate making procedures regardless of whether or not such has any affect on their jurisdiction. While I would have no objection to participating in Zone examinations I also feel we should be left free to proceed in accordance with our own abilities and time schedules, cooperating where possible with other Zones and jurisdictions.

2. I see absolutely no reason why this State or any other jurisdiction should take the time and incur the expense (paid by the rating bureau or advisory organization) to examine the financial condition of the bureaus and advisory organizations. These firms are supported in most part by very reputable carriers who are not about to permit them to operate under a financial deficit. If some evidence of financial condition is required, such can certainly be obtained from the annual C.P.A. reports which are the result of financial examinations required of the rating bureaus and advisory organizations by the companies which support them.

3. It is also my suggestion that during the next session of our Legislature we amend the law regarding the examination of rating bureaus and advisory organizations to permit the Director discretion as to when and how often he shall examine rating bureaus as well as advisory organizations. It must be remembered that all statistical data and rate making procedures utilized by bureau or advisory organization are required to be filed annually with the Rating Division and all of the material which we would review in an examination process has already in essence been filed and examined by technicians in the Rating Division.

We sincerely hope that this information will be helpful to you in responding to the Subcommittee.

Phil M. Williams

STATE OF ILLINOIS  
DEPARTMENT OF INSURANCE  
SPRINGFIELD

September 29, 1967

Department of Insurance  
State of Kansas  
Topeka, Kansas 66612

Attention: Mr. E. R. Eagle, Consultant

Re: Mr. Donald Karnes, Chief Examiner  
Chicago Office

Dear Sir:

Mr. Don Karnes has forwarded to the writer your letter of September 25, 1967, regarding the captioned subject.

The responsibility of the examination of authorized rating bureaus has been extended to the Rating Division, and we do examine rating bureaus by the use of rate analysts employed in our Rating Division with the assistance of the financial examiners in our Chicago office.

We have not had the opportunity to do an examination of the Western Actuarial Bureau since they became the parent organization of the Illinois Inspection and Rating Bureau. But it is our intent, when qualified individuals become available, to examine this rating bureau. We cannot establish any specific time as to when we shall be in a position to perform this examination. However, we would certainly be pleased to work with examiners from your office. We shall keep you advised as to our time schedule with regard to this particular situation.

For your information, the Department of Insurance recently examined the Illinois Inspection and Rating Bureau, and it will undoubtedly be some time before we again perform an examination of this organization.

Although final plans have not been established, we will probably attempt to examine both the WAB and the IIRB at the same time.

If we can be of any further assistance to you in this matter, do not hesitate to contact the undersigned.

Very truly yours,

John F. Bolton, Jr.  
Director of Insurance

By: Phil M. Williams, Supervisor  
Rating Division

STATE OF ILLINOIS  
DEPARTMENT OF INSURANCE  
SPRINGFIELD

Reply to

February 15, 1968

Room 1600, 160 North LaSalle Street  
Chicago, Illinois 60601  
Telephone 346-2000  
LD 312

Honorable Richard E. Stewart  
Superintendent of Insurance  
New York Insurance Department  
123 William Street  
New York, New York 10038

Re: Report of Subcommittee on Examination Procedures  
for Rating and Statistical Organizations (B4)

Dear Superintendent Stewart:

Director Bolton is in receipt of your letter of February 1, 1968 regarding this matter.



However, the copy of the Subcommittee's report together with the attachments were not received. Would you please forward same to my attention at our Chicago office?

I might add that we see little value in calling examinations on a zone basis for rating and statistical organizations, and believe that such examinations should be made by the domiciliary state. Insurance examiners have little or no background in rating matters, and the study of these statistical organizations must be made by rating technicians. From a solvency standpoint or the handling of funds, we have been accepting audits made by certified public accounting firms in our examinations and utilizing a technician from our rating division for the study of statistics.

Very truly yours,

JOHN F. BOLTON, JR.  
Director of Insurance

By: DONALD KARNES  
Chief Examiner

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STATE OF INDIANA  
THE DEPARTMENT OF INSURANCE

509 State Office Building

Indianapolis 46204

February 8, 1968

Honorable Richard E. Stewart  
Superintendent of Insurance  
State of New York  
123 William Street  
New York, New York 10038

In Re: Examination Procedures for Rating and  
Statistical Organizations (B4)

Dear Superintendent Stewart:

Answering your letter of February 1st, I attach a copy of a memo written by my Chief Examiner, Harold P. Mathauer. He expresses my views.

Very truly yours,

Joseph G. Wood  
Insurance Commissioner  
State of Indiana

From the Desk of  
HAROLD P. MATHAUER  
Chief Examiner

February 5, 1968

Commissioner Wood:

Re: Letter from Chairman, Subcommittee on Examination  
Procedures for Rating and Statistical Organizations (B4)

As to the topic in attached letter, I believe it would be proper to examine "Organizations doing a Nationwide Business" on the Zone basis.

Smaller intra-state organizations such as Hoosierland Rating Bureau and Indiana Rating Bureau could be examined only by the domiciliary state.

However, it would be desirable if NAIC set down certain guide lines for the depth of such state examinations.

H. B. Mathauer

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INSURANCE DEPARTMENT

STATE OF KANSAS

TOPEKA 66612

February 6, 1968

Honorable Richard E. Stewart  
 Superintendent of Insurance  
 State of New York  
 123 William Street  
 New York, New York 10038

Examination Procedure —  
 Rating & Statistical Organizations (B4)

Dear Superintendent:

This is in reply to your letter of February 1, 1968, with reference to the captioned subject.

A review of our files discloses some correspondence with the Illinois Department of Insurance in September of 1967 on this subject. This was with reference to the Western Actuarial Bureau of Chicago and its relation to the operation of the Kansas Inspection Bureau. For your information we are enclosing a copy of the letter received from Mr. Phil M. Williams, Supervisor Rating Division of the Illinois Department. This was in reply to our letter concerning the planned procedure on examination of rating organizations. From this we understand that there will be cooperation between that department and Kansas when an examination involving the Kansas Inspection Bureau will be made.

In view of this development, it appears that these examinations will be handled on a state or local basis and will not come under the association plan as employed in the examination of the various classes of regular insurance companies. This seems to coincide with some of the opinions expressed in the Subcommittee report (B4) (Mtg. #17) at the June 1967 Meeting of the NAIC.

Thank you for your letter and we trust this will be an adequate reply thereto.

Sincerely,

Frank Sullivan  
 Commissioner of Insurance

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STATE OF LOUISIANA  
 COMMISSIONER OF INSURANCE  
 P. O. Box 44214, Capitol Station  
 Baton Rouge, Louisiana 70804

April 3, 1968

Honorable Richard E. Stewart  
 Superintendent of Insurance  
 State of New York  
 123 William Street  
 New York, New York 10038

Re: Examination Procedures for Rating  
 and Statistical Organizations (B4)

Dear Commissioner Stewart:

It is my view that examination of rating and statistical organizations on a Zone basis would be preferable. Under Louisiana law, the Commissioner of Insurance may accept an examination properly certified by the supervisory official of the state of domicile of the organization. It is also my thought that the examination of rating and statistical organizations should be conducted every three years, or in the case of the Insurance

Rating Bureau possibly every two years, because of the tremendous amount of publicity and national interest currently manifested in automobile insurance.

Sincerely,

Dudley A. Guglielmo  
Commissioner of Insurance

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STATE OF MAINE  
INSURANCE DEPARTMENT

Augusta, Maine 04330

March 11, 1968

Honorable Richard E. Stewart  
Superintendent of Insurance  
State of New York  
123 William Street  
New York, New York 10038

Dear Superintendent Stewart:

Examination Procedures for Rating and Statistical Organizations (B4)

Responding to your February 1, 1968 communication and enclosures, I feel that Zone examinations of rating and statistical organizations would be most beneficial to this department.

It appears logical to assume that the results of an examination performed by representatives of several state departments could be much more objective than the findings of the departmental representative or representatives of the state of domicile. Furthermore, the Maine statutes presently provide for examinations at will, of any rating or statistical organization domiciled in the state and we believe that such prerogative is contained in the insurance statutes of the other states.

I trust that the above information is that which you desire. With kindest personal regards.

Very truly yours,

Frank M. Hogerty, Jr.  
Commissioner

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THE COMMONWEALTH OF MASSACHUSETTS  
DEPARTMENT OF BANKING AND INSURANCE  
DIVISION OF INSURANCE

Government Center -- State Office Building

100 Cambridge Street, Boston, Mass. 02202

February 28, 1968

Honorable Richard E. Stewart  
Chairman, Subcommittee on Examination  
Procedures for Rating and Statistical Organizations (B4)  
Insurance Department  
123 William Street  
New York, New York 10038

Dear Commissioner Stewart:

This is in answer to your letter of February 1, relative to zone examinations of rating bureaus.

There are three bureaus domiciled in Massachusetts including the New England Insurance Rating Association. In the past it has been next to impossible for Massa-

chusetts to receive assistance from the other New England states in the examination of the New England Insurance Rating Association. Lack of qualified examiners is the reason given.

However, I think for the larger rating bureaus, zone examinations are desirable particularly in view of the merger of N.B.C.U. and N.A.U.A.

The Massachusetts statutes permit the acceptance of the report of an exam made by the insurance supervisory official of another state.

Very truly yours,

C. Eugene Farnam  
Commissioner of Insurance

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STATE OF MICHIGAN  
INSURANCE BUREAU  
111 N. Hosmer Street  
Lansing, Michigan 48913

June 13, 1968

Letter to (B4) Subcommittee of the National Association  
of Insurance Commissioners:

Richard E. Stewart by Alexander E. Fox, Chairman — New York  
Richard S. L. Roddis by Mark Kai-Kee — California  
William R. Cotter by Robert A. Brian — Connecticut  
John F. Bolton, Jr. by Phil Williams — Illinois  
Robert D. Haase by Martin F. Raynoha — Wisconsin

Gentlemen:

Re: Association Examination Procedures for  
Rating and Statistical Organizations (B4)

In response to the letter by the Chairman dated February 1, 1968, Michigan would like to offer the following comments for consideration by the Subcommittee. We should like to mention that Michigan has and does chair the Property and Liability Subcommittee of the Zone 4 Committee of the National Association of Insurance Commissioners. This subcommittee of Zone 4 initiated the request for association examination procedures of rating and statistical organizations which was placed before the Examinations (B) Committee of the National Association of Insurance Commissioners at its December, 1967 meeting held in Dallas, Texas.

You will note in the report presented to the Examinations (B) Committee which appears in the Proceedings — 1967 Volume I, page 73, paragraph 3 sets forth two problems. They are:

“The (present) procedure does not provide an orderly means for inviting and selecting persons from the several states to participate in the examination of multi-state rating, advisory and statistical organizations. It does not indicate the qualifications required of persons working on such examinations, nor does it specifically indicate the purpose and scope of such examinations.”

With regard to the “means for inviting and selecting persons from the several states” Michigan recommends substantially the same procedure as employed in assembling a staff for the examination of multi-state insurance companies.

The suggested procedure is presently the responsibility of the Examinations (B) Committee.

With regard to the “qualifications required of persons working on such examinations” Michigan recommends that such persons must be fully versed in the rate regulatory laws providing for the establishment of and the governing of rating, advisory and statistical organizations.

With regard to the “purpose and scope of such examinations” Michigan recommends the following:

**Rating Organizations** — Since rating organizations are establishments authorized to perform rate making on behalf of member and subscriber insurers acting in concert under the rate regulatory laws of the several states, the primary purpose of examining such organizations should be to determine whether or not the activities of such organizations are being conducted in a manner not contrary to public interest. To make a periodic finding on this primary question the examination should involve perusal of all records of the activities of the organization not otherwise filed with the regulatory authority of jurisdiction during the normal rate filing process. The assistance of advisory and statistical organizations to the rating organization should be sought out and evaluated in relation to the extent of activity permissible by such organizations.

**Advisory Organizations** — The purpose of examining an advisory organization should be to determine whether or not the activities of such an organization are within the limits required by the rate regulatory laws. That is, their activities should not be that of a rating organization. Since such organizations have very little, if any, routine correspondence with the rate regulatory staff of each authority, the scope of examination of such an organization will require review of nearly all records within the organization.

**Statistical Organizations** — Since statistical organizations perform their work under statistical plans approved or recognized by the regulatory authorities of jurisdiction, there is no need to examine the statistical plans. The primary purpose of examining a statistical organization should be to determine whether or not the activities of such an organization exceed the extent permitted. That is, their activity should not be that expected of an advisory organization or a rating organization. The scope of the examination should involve review of records other than those pertaining to statistical plans, calls and compilations.

If an organization is a combination of two or more of the three types of organizations mentioned above, the purpose and scope of examining the organization should be a combination of that recommended for each separate organization.

In summary, Michigan feels that the regulatory authorities have an extremely responsible assignment in the licensing and regulation of rating, advisory and statistical organizations. These establishments are all very important to the business of insurance provided their activities are not contrary to the public interest. The determination of whether or not the activities of such organizations are not contrary to the public interest is not at all unlike the determination of whether or not an insurer is solvent. In both cases the public interest is a primary concern. In the case of rating, advisory and statistical organizations the concert activities of the members and subscribers under the authority of such an establishment must be carefully examined and regulated to avoid the development of conspiracies against the insurance buying public in pricing and marketing the kinds of insurance which are subject to the activities of such organizations. Such periodic determinations are as important as whether or not an insurer is in a satisfactory financial condition for the liquidation of its liabilities.

Because many of the past reports of examination of rating, advisory and statistical organizations have missed the primary purpose of examining such organizations, Michigan feels that the NAIC should develop a comprehensive program which would produce the desired results.

We hope that these views will be of assistance to the Subcommittee in carrying on its assignment.

Very truly yours,

William H. Larsen, Director  
Rates and Forms Section  
PROPERTY AND LIABILITY  
DIVISION

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STATE OF MISSOURI  
 DIVISION OF INSURANCE  
 JEFFERSON CITY 65101

March 15, 1968

Honorable Richard E. Stewart  
 Superintendent of Insurance  
 123 William Street  
 New York, N. Y. 10038

Re: Subcommittee on Examination Procedures for Rating  
 and Statistical Organizations (B4)

Dear Superintendent Stewart:

The present system for the calling of examinations at the discretion of the Commissioner of the domiciliary state has been satisfactory. The Missouri Casualty and Surety Rate Regulatory Law and the Missouri Workmen's Compensation Law impose the requirement of examination but authorize the acceptance by the Superintendent of Insurance of the report of an examination made by the Insurance Supervisory Official of another state in lieu of an examination provided for in Missouri. In my opinion the present system is superior to a zone system so long as such examinations continue to be made.

As regards fire insurance, the Missouri Fire Insurance Code authorizes the Superintendent of Insurance to examine as he deems necessary. Also, at the present time the Fire Insurance Rating Bureaus are operating only within the State of Missouri and periodic examination is made.

In addition to the foregoing, I must budget and assign responsibilities to more significant items such as the filings of such rating organizations and the examination of individual insurance companies.

If the Subcommittee is aware of any significant problem in this regard, I would like to be informed accordingly and have an opportunity to reconsider my position.

Yours very truly,

ROBERT D. SCHARZ  
 Superintendent

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STATE OF MONTANA

Helena, Montana 59601

February 8, 1968

Honorable Richard E. Stewart  
 Chairman, Subcommittee on Examination  
 Procedures for Rating and Statistical  
 Organizations (B4)  
 123 William Street  
 New York, New York 10038

Your circular of February 1, 1968, asking the Commissioner's views relative to examinations of rating and statistical organizations in light of this State's law, is acknowledged.

Please be advised Montana law requires the examination by this Department of rating and statistical organizations, not less often than once every three (3) years. However, such examination can be waived by the Commissioner upon the filing with him of a report of examination made by some other Insurance Department, or proper supervising officer, within the three (3) years. So far as Montana law is concerned, we would be inclined to prefer the Zone basis of examination, using the same, or like criteria, as is used in examining insurers.

E. V. "SONNY" OMHOLT

State Auditor & Ex Officio  
 Commissioner of Insurance

By: Clyde Gummow  
 Chief Deputy Insurance Commissioner

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STATE OF NEVADA  
INSURANCE DIVISION  
Carson City, Nevada 89701  
(702) 882-7427

February 23, 1968

The Honorable Richard E. Stewart  
Superintendent of Insurance  
State of New York  
123 William Street  
New York, New York 10038

RE: Rating and Statistical Organizations (B4)

Dear Dick:

Further to my letter of February 16th in the above captioned matter I have now heard from my Chief Examiner and would like to pass along his recommendations.

He concurs with our feeling that the organizations or bureaus could or should be made on his own basis, however he feels that the examiners participating for the Zone States should have previous experience with the rules, reporting methods of the companies to the bureaus, and in the promulgation of rates. As I see it his indication is well taken as perhaps the average examiner without previous experience in this respect could not participate too well in such an examination.

Mr. Shimko has also called my attention to second paragraph of your letter of February 1st and the relation to "or if the calling of examinations at the discretion of the Commissioner of the domiciliary state might be satisfactory." He indicates that surely this phrase does not pre-empt or vitiate the authority of a commissioner in any particular state to examine any of these associations or bureaus on any justified complaint. Perhaps this is covered in the NAIC report on that subject. In relation to that, you indicated that you had sent the subcommittee report, however it was not attached and would appreciate your forwarding to Joseph G. Shimko, 70 Prospect Park, S. W., Brooklyn, New York a copy of that (B4) report at the earliest possible date, as well as additional copy for my own file.

Further to this, my Chief Examiner wonders if anyone has suggested that this type of call should be with the Chairman of the Examinations Committee of the NAIC. His reasoning for this suggestion is because of the multitude of states that are involved in these associations, pools and/or bureaus. He believes that the controlling factor does not necessarily have to be with the domiciliary state of that particular bureau or association.

Hopeful that this further information is helpful to you and the members of the Committee and if we can be of further service, please do not hesitate to let me know.

Very truly yours,

LOUIS T. MASTOS  
Commissioner of Insurance  
cc: Joe Shimko, Chief Examiner

STATE OF NEVADA  
INSURANCE DIVISION  
Carson City, Nevada 89701  
(702) 882-7427

February 16, 1968

The Honorable Richard E. Stewart  
Superintendent of Insurance  
State of New York  
123 William Street  
New York, New York 10038

Dear Dick:

Your inquiry of February 1st relative to the Subcommittee on Examination Procedures for Rating and Statistical Organizations (B4) is acknowledged.

I am sure that you would agree that much of the examination procedures of a rating

and statistical organization is common to all states such as the organization, constitution, bylaws, minutes and accounting. Likewise rating procedures are the same, but with minor variations. A Zone Examination could facilitate such examinations.

The actual rate making for any state involves the statistics of that state, with consideration given to experience outside the state.

We feel that an examiner from each state should be represented but that the examination could be made on a Zone basis. The report from each state should be confined to the statistics and rating procedures as involved in his particular state alone as well as covering the operations therein, but the report on general matters could be the same for all states participating.

I have also written to my chief examiner for any remarks that he might have that would be helpful and upon receipt thereof if anything other than what I have outlined herein, I will forward them to you.

Hopeful this information is helpful to you in your consideration in this matter and if we can be of further help, please do not hesitate to let me know.

Very truly yours,

LOUIS T. MASTOS  
Commissioner of Insurance

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THE STATE OF NEW HAMPSHIRE

INSURANCE DEPARTMENT

State House Annex, Concord 03301

February 13, 1968

Hon. Richard E. Stewart, Superintendent of Insurance  
State of New York — Insurance Department  
123 William Street  
New York, New York 10038

Dear Mr. Stewart:

I acknowledge your letter of February 1, asking for a statement of my views on the examination procedures for rating and statistical organizations. It seems to me that this could be handled very nicely by giving the domiciliary state the right to call the examinations, having in mind the state's statutes which require at least that rating organizations be examined at regular intervals. I believe that these examinations should be called on a basis which would give the Zones in which the organizations operate the right to participate if they so desire.

Sincerely yours,

Donald Knowlton  
Commissioner

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STATE OF NEW JERSEY

DEPARTMENT OF BANKING AND INSURANCE

March 27, 1968

Superintendent Richard E. Stewart  
State of New York Insurance Department  
123 William Street  
New York, New York 10038

Dear Superintendent Stewart:

In response to your letter of February 1, 1968, as Chairman of the Subcommittee on Examination Procedures for Rating and Statistical Organizations (B4), you are advised that Title 17:29A-12 of the Revised Statutes of New Jersey authorizes the Commissioner, whenever he deems it expedient, but at least once in every five years, to either cause an examination of the business, affairs and methods of operation of each rating organization doing business in the State to be made or, in his discretion,



waive such examination upon proof that such organization has, within a reasonably recent period, been examined by a public official or department of another state pursuant to the laws of such state.

Since Commissioner Howell is clothed with authority to proceed in either direction, we would prefer to have the rating organization examined by the domiciliary state, with participation in such examination by other states on a zone basis and preference to the specific states that request an opportunity to participate in such examination.

Very truly yours,

Horace J. Bryant, Jr.  
Deputy Commissioner

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STATE OF NORTH CAROLINA  
INSURANCE DEPARTMENT

RALEIGH 27602

February 8, 1968

Superintendent Richard E. Stewart  
State of New York Insurance Department  
123 William Street  
New York, N. Y. 10038

Re: Subcommittee (B4) Examination Procedures  
for Rating and Statistical Organizations

Dear Superintendent:

This has reference to your letter of February 1, 1968 requesting my views on the examination procedures for rating and statistical organizations.

In my opinion, the examination of rating and statistical organizations on a Zone basis would be preferable.

Yours very truly,

Edwin S. Lanier  
Commissioner of Insurance

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STATE OF OREGON  
INSURANCE DIVISION

158 12th Street, N.E.

Salem, Oregon 97310

February 27, 1968

Honorable Richard E. Stewart  
Superintendent of Insurance  
123 William Street  
New York, New York 10038

Dear Dick:

Re: Examination Procedures for Rating and Statistical  
Organizations, (B4) Subcommittee of National  
Association of Insurance Commissioners

In view of the requirement of Oregon law and laws of other states for examination of each rating organization at least every five years, and of each advisory organization as often as is considered expedient, a regular Zone procedure for calling such examinations would seem logical to me.

Yours very truly,

James R. Faulstich  
Insurance Commissioner

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COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT  
HARRISBURG

March 14, 1968

Honorable Richard E. Stewart  
Superintendent of Insurance  
State of New York Insurance Department  
123 William Street  
New York, New York 10038

Dear Dick :

Our Department has reviewed the proposals of the National Association of Insurance Commissioners' Subcommittee on Examination Procedures for Rating and Statistical Organizations (B4).

The Pennsylvania Insurance Department has no objection to the calling of examinations of Rating and Statistical Organizations at the discretion of the Commissioner of the domiciliary state. We would recommend the inclusion of a provision that the domiciliary state Commissioner give notice of the impending examination to the Chairmen of all zones involved. This provision is provided for in Mr. Cahill's letter of September 8, 1967.

With kindest personal regards, I am

Sincerely,

David O. Maxwell

COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT  
HARRISBURG 17120

February 13, 1968

Honorable Richard E. Stewart  
Superintendent of Insurance  
State of New York  
Insurance Department  
123 William Street  
New York, New York 10038

Dear Superintendent Stewart:

Insurance Commissioner David O. Maxwell asked me to reply to your letter of February 1, with reference to the subcommittee of examination procedures for rating and statistical organizations (B4).

Insurance Commissioner Maxwell will forward to you his comments regarding this report prior to March 30, 1968.

Thank you.

Very truly yours,

Richard W. Krimm  
Deputy Insurance Commissioner

STATE OF SOUTH CAROLINA  
 DEPARTMENT OF INSURANCE  
 Federal Land Bank Building — 1401 Hampton Street  
 Columbia, South Carolina 29201  
 March 21, 1968

Honorable Richard E. Stewart  
 Superintendent of Insurance  
 State of New York  
 Insurance Department  
 123 William Street  
 New York, New York 10038

Re: (B4) Subcommittee NAIC Association Examination  
 Procedures for Rating and Statistical Organizations

Dear Superintendent Stewart:

This is in reply to your letter of February 1, 1968, requesting my views on the above subject.

Examinations of the organizations referred to above, conducted at least once each five years, on a Zone basis would be compatible with South Carolina Statutes. Such a procedure would be preferable to the calling of examinations at the discretion of the Commissioner of the domiciliary state.

Very truly yours,

CHARLES W. GAMBRELL  
 Chief Insurance Commissioner

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STATE OF SOUTH DAKOTA  
 DEPARTMENT OF INSURANCE

PIERRE 57501

March 26, 1968

Mr. Richard E. Stewart  
 Chairman, Subcommittee on Examination  
 Procedures for Rating and Statistical  
 Organizations (B4)  
 State of New York  
 Insurance Department  
 123 William Street  
 New York 10038

Dear Superintendent Stewart:

The South Dakota Department of Insurance prefers that examinations of companies be on a zone basis.

Sincerely yours,

WARREN E. DIRKS  
 Commissioner

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STATE OF TENNESSEE  
DEPARTMENT OF INSURANCE AND BANKING  
NASHVILLE 37219

February 15, 1968

Mr. Richard E. Stewart  
Chairman, Subcommittee on  
Examination Procedures for  
Rating and Statistical Organizations (B4)  
New York Insurance Department  
123 William Street  
New York, New York 10038

Re: Subcommittee on Examination for Rating and Statistical  
Organizations (B4)

Dear Superintendent Stewart:

In response to your recent letter concerning the captioned subject matter, it is the opinion of this Department that examinations of rating and statistical organizations should be conducted on a Zone basis.

Very truly yours,

David M. Pack  
Commissioner

cc: Richard S. L. Roddis — California  
William R. Cotter — Connecticut  
John F. Bolton, Jr. — Illinois  
Robert D. Haase — Wisconsin

STATE OF WISCONSIN  
4802 Sheboygan Avenue  
Madison 53702

April 1, 1968

Hon. Richard E. Stewart  
Superintendent of Insurance — State of New York  
Chairman — Subcommittee on Examination Procedures  
For Rating and Statistical Organizations (B4)  
123 William Street  
New York, New York 10038

Dear Dick:

We have reviewed the discussions of the procedures for examining rating and statistical organizations reported in the minutes of the last two meetings of the Subcommittee and in the letters attached to the minutes. We offer the following comments:

Rating organizations, advisory organizations, and statistical organizations shall be considered as "organizations engaged in the insurance business" for purposes of considering the duties of the Committee on Examinations (1967 Proceedings NAIC, Volume 2, page 242). No problem exists when only a single state is affected. Essentially the same procedures now used for calling an Association examination of an insurance company shall be used in calling an examination of a rating, advisory, or statistical organization which is authorized in more than one state, except that premium writings cannot be used as a basis for determining participation by the several states. Instead, we suggest that the determining factor for participation be the number of states in which the organization is authorized. The basis of the examination would then be:

1. Single-State Organizations

Examined by domiciliary state periodically as prescribed by its laws and regulations.

2. Multi-State Organizations Operating Within the Domiciliary Zone

a. Operating in 3 or less states. Domiciliary state determines

whether to examine without invitation to other states to participate or whether to invite participation for a joint-state examination.

- b. Operating in 4 or more states. Domiciliary state invites Zone participation through the NAIC, following the usual NAIC company examination procedures, to assist the domiciliary state, which will also represent the Zone. Other states within the zone of the domiciliary state may participate to the extent requested.
3. Multi-State Organizations Operating in More Than the Domiciliary Zone
    - a. Domiciliary state invites Zone participation through NAIC, using the same procedure as for an insurance company Association examination. Any zone in which an organization is authorized to operate shall be entitled to be represented in such designated Association examination.
    - b. Domiciliary state shall represent its zone in such Association examination. (See 2. b. above.)
  4. Frequency of Association Examinations
 

Such organizations shall be examined as prescribed by the laws and regulations of the domiciliary state but not less than once in every 5 years.
  5. Coordination of Examinations
 

If possible and feasible, examinations of statistical and data processing organizations and other allied organizations subject to examination should be coordinated with the examination of the rating organization where affiliation or proximity of operations is such as to make this desirable or economical.

I hope that these suggestions are helpful.

Sincerely,

Robert D. Haase  
Commissioner of Insurance

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COMMISSIONER KUECKELHAN: There were meetings of the only two subcommittees, the reports of these subcommittees are attached and I move the adoption of the report.

PRESIDENT BENTLEY: The Chairman moves the adoption of this report. Is there a second?

COMMISSIONER PRICE: Second.

PRESIDENT BENTLEY: Commissioner Price seconds the motion. Is there objection to the adoption of the report? Hearing no objection, the report is adopted

PRESIDENT BENTLEY: The next committee report is that of the Federal Liaison Committee. The Hon. Richard E. Stewart of New York will make the report and I now recognize him.

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FEDERAL LIAISON (C) COMMITTEE

AGENDA - MTG. #31

TUESDAY A.M.

JUNE 18, 1968

9:00-10:15

BALLROOM A

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Reference

1968 Proc. VOL. I pp. 105-107

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1. Implementation of Hughes Panel Report.
  2. S.E.C. Rule 10b-12.
  3. Automobile Insurance Studies.
  4. Any other matter submitted for consideration.
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FEDERAL LIAISON (C) COMMITTEE Report  
(Mtg. 31)

The Federal Liaison (C) Committee meeting was held in Ballroom B of the Portland-Hilton Hotel on June 18, 1968, as part of the joint meeting with the Civil Disorders - Insurance Problems (A7) Committee.

Apart from the Liaison activities with the Federal Government with respect to fire insurance in the central cities, the Chairman reported that a submission had been made to the Securities and Exchange Commission on a proposed Rule 10b-12 relating to stock dividends. The letter pointed out problems raised by the proposed rule under established insurance accounting principles and offered NAIC cooperation in making revisions. The Chairman also reported that pursuant to discussions at the Honolulu meeting, the Committee had offered NAIC technical assistance and other cooperation with the Department of Transportation, Senate Anti-Trust Committee and other pending or contemplated inquiries into automobile insurance.

There were no industry submissions or comments from the floor and there was no further discussion in the Executive Session. There being no further business, the meeting was adjourned.

Hon. Richard E. Stewart, Chm., N. Y.; Hon. George M. Cowden, V.Chm., Texas; Hon. Richard S. L. Roddis, Calif.; Hon. William R. Cotter, Conn.; Hon. Broward Williams, Fla.; Hon. James L. Bentley, Ga.; Hon. John F. Bolton, Jr., Ill.; Hon. Lorne R. Worthington, Iowa;

Hon. Newton I. Steers, Jr., Md.; Hon. C. Eugene Farnam, Mass.; Hon. David J. Dykhouse, Mich.; Hon. Walter D. Davis, Miss.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Donald Knowlton, N. H.; Hon. Charles R. Howell, N. J.; Hon. Eugene P. Brown, Ohio; Hon. T. Nelson Parker, Va.; Hon. Lee I. Kueckelhan, Wash.; Hon. William G. Walton, Wyo.

**SUPERINTENDENT STEWART:** Mr. Chairman, I don't think there is any particular controversy involved in this report and I would respectfully move its adoption.

**PRESIDENT BENTLEY:** Thank you, Mr. Stewart. Is there a second to the motion for the adoption of this report?

**COMMISSIONER HOWELL:** I'll second it.

**PRESIDENT BENTLEY:** Seconded by Commissioner Howell of New Jersey. Is there any comment or discussion on this report? Is there objection to the adoption of the report? The Chair hears none and the report is adopted.

PRESIDENT BENTLEY: The next committee to report is the Committee on Laws and Legislation, headed by California Superintendent Richard L. Roddis, whom I now recognize.

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LAWS AND LEGISLATION (D) COMMITTEE

AGENDA - MTG. #34

WEDNESDAY A.M. JUNE 19, 1968

9:00-10:15 BALLROOM A

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Reference

1968 Proc. VOL. I pp. 109-131

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1. To Prepare Model Legislation to Modify Schedule "P" Statutes (D1) Subcom. Report (Mtg. 4)  
 Hon. David J. Dykhouse, Chm., Mich.  
 Refs: 1966 Proc. VOL. II p. 387 (additional references)  
 1966 Proc. VOL. II p. 388 NR  
 1967 Proc. VOL. I pp. 109-110  
 1967 Proc. VOL. II pp. 369-372  
 1968 Proc. VOL. I pp. 113-115
2. To Draft Model Legislation Relating to Insurance Holding Companies (D2) Subcom. Report (Mtg. 26)  
 Hon. Benjamin C. Neff, Jr., Chm., Neb.  
 Refs: 1966 Proc. VOL. II pp. 299; 308-310  
 1967 Proc. VOL. I p. 105  
 1967 Proc. VOL. II p. 365  
 1968 Proc. VOL. I p. 117
3. To Draft Recommendations, including Legislation if necessary to Regulate Long Term Credit Insurance (D3) Subcom. Report (Mtg. 18)  
 Hon. William G. Walton, Chm., Wyo.  
 Refs: 1961 Proc. VOL. I pp. 300-305 Model Bill  
 1967 Proc. VOL. I pp. 105-108  
 1967 Proc. VOL. II p. 365  
 1968 Proc. VOL. I pp. 119-120
4. To Draft Recommendations, including Legislation if necessary, dealing with Unauthorized Insurers (D4) Subcom. Report (Mtg. 15)  
 Hon. James R. Faulstich, Chm., Ore.  
 Refs: 1967 Proc. VOL. I pp. 216-217  
 1967 Proc. VOL. II pp. 365-366  
 1968 Proc. VOL. I p. 121
5. To Study Procedures of Reorganization, Receivership and Liquidation (D5) Subcom. Report (Mtg. 16)  
 Hon. John F. Bolton, Jr., Chm., Ill.  
 Refs: 1966 Proc. pp. 30-32 (Uniform Liquidation Act - 14 States & Puerto Rico)  
 1967 Proc. VOL. I p. 388  
 1968 Proc. VOL. I p. 123



6. To Study Administration Experience of Proxy Regulations and Insider Trading Regulations and Make Recommendations (D6) Subcom. Report (Mtg. 22)

Hon. David O. Maxwell, Chm., Pa.

Refs: 1965 Proc. VOL. I pp. 155-170 (Proxy Regulations)  
 1965 Proc. VOL. I pp. 175-178 (Stockholder Information Supplement)  
 1966 Proc. VOL. I pp. 111-120 (Insider Trading Regulations)  
 1966 Proc. VOL. II pp. 339-394 (Summary and Suggested Revisions)  
 1968 Proc. VOL. I p. 111

7. Presentation by Professor Lester B. Strickler  
 School of Business, Oregon State University  
 Study of Premium Taxation.
8. Any other matter submitted for consideration.

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## LAWS AND LEGISLATION (D) COMMITTEE Report

(Mtg. 34)

The Meeting of the Laws and Legislation (D) Committee was held in Ballroom A of the Portland Hilton Hotel on June 19, 1968, commencing at 9:00 A.M. A quorum was present.

The matters upon which action was taken consisted entirely of reports of six Subcommittees. In each case the report was presented in open session by, or on behalf of, the Chairman of the Subcommittee, received without objection, and further acted upon in Executive Session. All reports had been printed and made generally available prior to the Meeting and discussion or comments by any persons present were invited by the Chairman during the open session. There was discussion concerning several of the reports.

After discussion, action was taken on each of the Subcommittee Reports during Executive Session, as follows:

1. Report of the Subcommittee To Prepare Model Legislation To Modify Schedule "P" Statutes (D1): On motion, seconded and carried, the report was adopted. Upon its request, New York's vote against adoption is recorded.
2. Report of the Subcommittee To Draft Model Legislation Relating to Insurance Holding Companies (D2): On motion, seconded and carried, the report was adopted.
3. Report of the Subcommittee To Make Recommendations, including Drafting of Model Legislation, if necessary, to Regulate Long Term Credit Insurance (D3):

A motion was made and seconded to adopt the report.

A substitute motion was made, seconded and carried to remand the Report and the subject to the (D3) Subcommittee for further study. Upon its request, Texas' vote in favor of the motion is recorded.

A motion was made to amend the (D3) Subcommittee Report in certain specified respects. The Chairman ruled the motion out of order.

A motion was made, seconded and carried to rescind the motion to remand the report and the subject to the (D3) Subcommittee. Upon its request, Texas' vote against the motion is recorded.

A motion was made, seconded and carried to amend the (D3) Subcommittee Report to delete the recommendation to except real estate first mortgage transaction from regulation and to provide that the recommended amendment to Section 2 A (2) of the NAIC Model Credit Insurance Bill read as follows rather than as set forth in the report as received:

“All life insurance and all accident and health insurance in connection with loans or other credit transactions shall be subject to the provisions of this Act, except such insurance in connection with a loan or other credit transactions of more than [five] *ten* years duration; nor shall insurance be subject to the provisions of this Act where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.”

Upon its request Texas' vote against the motion is recorded.

A motion to adopt the report, as amended, was made, seconded and carried. Upon its request, Texas' vote against the motion is recorded.

It was the sense of the Committee that the (D3) Subcommittee should continue to study the subject in cooperation with the Industry Advisory Committee, in the manner suggested in the Subcommittee Report.

4. Report of the Subcommittee To Make Recommendations, including drafting of Model Legislation, if necessary, dealing with Unauthorized Insurers (D4): On motion made, seconded and carried, the report was adopted.

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Matter in [brackets] has been deleted.  
Matter in *italics* has been added.

5. Report of the Subcommittee To Study Procedures of Reorganization, Receivership and Liquidation (D5): On motion made, seconded and carried, the report was adopted.
6. Report of the Subcommittee To Study Administration Experience of Proxy Regulations and Insider Trading Regulations and Consider Suggested Revisions (D6): On motion made, seconded and carried, the report was adopted. Upon request of the Chairman of the Subcommittee, the Chairman ordered that three typographical and editorial corrections, not affecting the substance of the report, be made and that the report as published in the Proceedings be as so corrected.

During the open session, Professor Lester B. Strickler of the School of Business of Oregon State University briefly described the objects, scope and status of a study he is making of premium taxation. Such presentation was made pursuant to a request made by Professor Strickler prior to the meeting.

No additional matters were brought before the meeting, which was adjourned upon conclusion of the Executive Session.

Hon. Richard S. L. Roddis, Chm., Calif.; Hon. C. Eugene Farnam, V.Chm., Mass.; Hon. Allan W. Horne, Ark.; Hon. John F. Bolton, Jr., Ill.; Hon. Lorne R. Worthington, Iowa; Hon. Robert D. Preston, Ky.; Hon. David J. Dykhouse, Mich.; Hon. Thomas C. Hunt, Minn.; Hon. Walter D. Davis, Miss.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Louis T. Mastos, Nev.; Hon. Donald Knowlton, N. H.; Hon. Ralph F. Apodaca, N. M.; Hon. Richard E. Stewart, N. Y.; Hon. James R. Faulstich, Ore.; Hon. David O. Maxwell, Pa.; Hon. Warren E. Dirks, S. D.; Hon. David M. Pack, Tenn.; Hon. Durwood Manford, Texas; Hon. C. N. Ottosen, Utah; Hon. Frank R. Montgomery, W. Va.; Hon. Robert D. Haase, Wis.; Hon. William G. Walton, Wyo.

## To Prepare Model Legislation to Modify Schedule "P"

(D1) Subcom. Report (Mtg. 4)

The Subcommittee To Prepare Model Legislation to Modify Schedule "P" (D1) met at the Portland Hilton Hotel in Portland, Oregon, at 9:00 a.m. on June 17, 1968. It met jointly with the Actuarial (F5) Subcommittee.

The Chairman reviewed the model legislation recommended by this Subcommittee in Honolulu on December 4, 1967 (ref: 1968 Proc. Vol. I pp. 113-115; 275-282), and the studies and memoranda on this subject circulated since last December to the members of this Subcommittee and also to the members of the Actuarial (F5) Subcommittee. Copies of these studies are attached to the report of the (F5) Subcommittee (ref: see pages 817-882) and made a part hereof. He then asked for a discussion of the proposals.

Mr. Graves of the Mutual Insurance Advisory Association described the different sections of the proposed model legislation pointing out where the legislation strengthens and expands the present Schedule "P" statutes for establishing adequate reserves and minimum reserves. The purpose of the proposed legislation, he said, was not designed to weaken or soften the regulation of loss reserves, but was designed to strengthen that regulation by providing for minimums equivalent to the present minimums and providing for additional requirements to be prescribed by regulations made by the Commissioners from time to time. He offered for the record a letter from Miss Ruth Salzmann to Dr. Graves regarding several of the memoranda which had been circulated to the Subcommittee. A copy is attached to the report of the Actuarial (F5) Subcommittee (ref: see pages 817-882) and is made a part hereof.

After discussion of the proposed model bill and the memoranda circulated since the Honolulu meeting, it was moved, seconded and adopted that the recommendation adopted on December 4, 1967, be reaffirmed, which was that the attached legislation be recommended to the parent Committee and adopted by the NAIC, (ref: 1968 Proc. Vol. I pp. 113-115; 275-282).

Each insurance company transacting business in this State shall, at all times, maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred, whether reported or unreported, which are unpaid and for which such company may be liable and to provide for the expenses of adjustment or settlement of losses and claims. Such reserves shall be computed in accordance with regulations made from time to time by the (Commissioner, Superintendent,

Director), after due notice and hearing, upon reasonable consideration of the ascertained experience and the character of such kinds of business for the purpose of adequately protecting the insured and securing the solvency of such company.

Whenever the loss and loss expense experience of such company shows the reserves, calculated in accordance with such regulations, to be inadequate, the (Commissioner, Superintendent, Director) may require such company to maintain additional reserves.

The minimum reserve requirements prescribed by the (Commissioner, Superintendent, Director) in the regulations promulgated under authority of this section for unpaid losses and loss expenses incurred during each of the most recent three years for coverages included in the lines of business described in the annual statement as workmen's compensation, liability other than auto (B.I.), and auto liability (B.I.) shall not be less than the following: for workmen's compensation, 65% of premiums earned during each year less the amount already paid for losses and expenses incidental thereto incurred during said year; for liability other than auto (B.I.) and auto liability (B.I.), 60% of premiums earned during each year less the amount already paid for losses and expenses incidental thereto incurred during said year.

The (Commissioner, Superintendent, Director) may, by regulation, prescribe the manner and form of reporting pertinent information concerning the reserves provided for herein.

Inasmuch as the sole assignment of the Subcommittee was the recommendation of this model legislation, it is respectfully requested that the Subcommittee be discharged.

Hon. David J. Dykhouse, Chm., Mich.; Hon. Charles R. Howell by W. Harold Bittel, N. J.; Hon. Frank J. Montgomery, W. Va.; Hon. John F. Bolton, Jr., Ill.; Hon. Charles W. Gambrell, S. C.

## To Draft Model Legislation Relating to Holding Companies

## (D2) Subcom. Report (Mtg. 26)

The Subcommittee (D2) To Draft Model Legislation Relating to Holding Companies Meeting was held in the Galleria Room of the Portland Hilton Hotel on June 17, 1968. The Chairman reported on the two Subcommittee Meetings held since the Regular Meeting and on the appointment of an Industry Committee. The Chairman pointed out that the efforts of the Subcommittee are being directed toward finalizing the Subcommittee's work by the Regular Meeting in December. To this extent the Subcommittee expects to meet at least thrice prior to that time. There were no industry submissions or comments from the floor. There being no further business, the meeting was adjourned.

The reports on the interim meetings were as follows :

On March 11, 1968 the Subcommittee met in Jackson Hole, Wyoming. At that time the Subcommittee discussed the problems of holding companies and the ramifications involved. The areas of concern were delineated and were set forth as follows :

1. The need for full disclosure, subject to verification by examination concerning holding company activities which affect insurance company operation.
2. Surveillance and control over distributions from an insurer to a holding company.
3. Disclosure and approval of transactions between an insurer and its affiliates including standards for reporting, allocation of expense and record keeping to facilitate review of transactions.
4. Approval prior to acquisition of control of an insurer.
5. Self-sufficiency of the insurer including finances and management.
6. Prohibition against use of a holding company to accomplish indirectly what an insurer is prohibited from doing directly.
7. Individual state control of foreign holding companies.
8. Auxiliary activities in which insurance companies may engage through subsidiaries.
9. Possible liberalization of debt securities which might be issued by a company.
10. Limitations on number or assets which a holding company could control.
11. Difficulties in valuation of subsidiary stock.
12. Difficulties in valuation of surplus which may be transferred to a holding company either in formation or following.
13. Problems involving management and service contracts between holding companies and their subsidiaries.

In addition, it was determined that an Industry Committee be appointed and that the Committee consist, to as great an extent as possible, of company representatives who were in top management positions.

The Industry Committee was appointed and the following individuals were named :

J. Henry Smith, President, The Equitable Life Assurance Society of the United States; John W. Joanis, President, Sentry Life Insurance Company; E. J. Faulkner, President, Woodmen Accident and Life Insurance Company; James S. Kemper, Jr., President, Lumbermens Mutual Casualty Company; Walter J. Jeffery, Chairman of the Board and President, United States Fidelity and Guaranty Company; O. L. Frost, Jr., Vice President, Occidental Life Insurance Company of California; Donald S. MacNaughton, Executive Vice President, The Prudential Insurance Company of America; T. S. Burnett, Chairman of the Board, Pacific Mutual Life Insurance Company; John H. Filer, General Counsel, Aetna Life Insurance Company; Fred H. Merrill, Chairman of the Board, Fireman's Fund Insurance Co.; George H. Kline, Vice President, Secretary and General Counsel, Allstate Insurance Company; and W. Douglas Bell, Executive Vice President and General Counsel, State Mutual Life Insurance Company of America.

A joint meeting of the Industry Committee and this Subcommittee was held in Chicago at the Palmer House on May 9th and 10th, 1968. At that time the following questions were submitted for their consideration and advice.

1. Are holding companies or other persons controlling insurance companies affected with a public interest to the extent that the activities of the holding organization which affect insurance companies should be regulated?
2. Are there any forms of holding companies or companies otherwise exercising control of insurance corporations which in the interest of the public should be required to divest their control or be prohibited from acquiring interests in insurance corporations?
3. If the insurance activities of holding companies are affected with the public interest what agency or agencies should regulate these activities?
4. What form or forms of regulation should the agency or agencies exercise?
5. What public or corporate needs justify holding companies controlling insurance companies?
6. Do insurance holding companies provide an economic advantage to any form of insurance company corporate structure?

In addition the following questions involve what transactions should be regulated, prohibited or disclosed.

7. Are there merger or anti-trust considerations involved in holding company activities?
  - (a) if so what are the areas of concern?
  - (b) what should be done in these areas?
  - (c) who should do it?
8. Are surveillance and control by a regulatory body, over distributions from an insurer to a holding company in the interest of the public?
  - (a) Should distributions be limited to certain funds of an insurer?
  - (b) Should notice to an approval by a regulatory body be a condition precedent?
  - (c) What standards of approval should govern the administrator?
9. Is there a need for full disclosure, subject to verification by examination, of those holding company activities which affect insurance company operation?
  - (a) What, if any, limitations should be placed on the powers to examine?
10. What disclosure and approval of transaction between a holding company, an insurer or subsidiaries is necessary, and what standards from reporting, allocation of expense and record keeping should be required to facilitate review of transactions?
11. Should the insurer be self-sufficient in all areas including finances and management?
12. Should approval prior to acquisition of control of an insurer be required?
  - (a) What standards should be used?
13. Should approval prior to acquisition by an insurer of control of a subsidiary be required?
  - (a) What standards should be used?
14. To what extent and in what areas should the individual states control the activities of holding companies controlling non-domestic insurers licensed to do business in such individual states?
15. What additional personnel, skills or funds would be necessary on the part of an insurance department to properly regulate holding company activities?
16. What are the auxiliary activities that an insurance company should be permitted to engage in through subsidiaries?
17. Should subsidiaries of insurers be wholly owned?
18. What debt securities should be issued by an insurer?
  - (a) If other than those permitted at the present time what safeguards should be exercised?

19. Should an insurer be permitted to invest in the debt securities of its subsidiaries or the holding company of any of the holding company's subsidiaries or in the stock of the holding company or any of its securities?
  - (a) If the answer is yes, under what circumstances should such investment be permitted?
20. What standards should be developed in the valuation of subsidiary stock?
21. What standards, if any, should be developed as to the amount of surplus which an insurer may transfer to form a holding company?
  - (a) What standards should be developed in the valuation of the securities transferred?
22. Should there be a limitation on the number of insurance companies or the amount of insurance company assets which a holding company can control?
  - (a) Should the type of insurance company owned affect the number of companies permitted to be owned?
  - (b) What anti-trust or conflict of interest factors are involved and how may these problems be met?
  - (c) If the number of companies or assets should be controlled what standards should be developed?
23. Should there be a direct prohibition against use of a holding company to accomplish indirectly what an insurer is prohibited from doing directly?
24. What management or service contracts should be permitted between holding companies, insurers and their subsidiaries and under what conditions?
25. What liberalization, if any, should be made in the permitted investments of an insurance company?
26. What control, if any, should the regulatory body exercise over the holding company's proxy statements as they pertain to the insurance company?
27. What control, if any, should the regulatory body exercise over the financial statements of the insurer which are furnished by the holding company to its stockholders or creditors?
28. Should the corporate purposes of the holding company be limited?
  - (a) If so, in what areas?
29. Should a holding company be permitted to have a name similar to an insurance company?
30. What economic effects will the holding company concept or liberalization of insurance company investments have on (a) the general business community and (b) small insurance companies?
31. What personnel or corporate conflicts of interest might be experienced between holding companies, insurers or subsidiaries and how can the conflicts be controlled?
32. When an insurer is controlled by a holding company will the investment philosophy shift from favoring the insured to favoring the stockholders?
33. To what extent may a mutual insurer or a stock insurer issuing a par policy advertise its subsidiaries in the sale of insurance?
34. Should state securities acts (blue sky laws) be amended to require the registration or sale of holding company and subsidiary stocks on the same basis as insurance company stocks?
35. To what extent is the availability of funds for purchasing subsidiaries or transferring to holding companies an admission of underpaid stockholder or policyholder dividends?
36. Does diversification create a primary benefit to management and a secondary benefit to policyholders?
37. To what extent should the transfer of assets be permitted between holding companies, insurers or subsidiaries?



- (a) Does it make a difference if there are minority stockholders in the insurer or subsidiary?
  - (b) Does it make a difference if there is consideration involved?
  - (c) What control over the valuation of assets exchanged should be exercised by the regulatory body?
38. What standards should be used to determine when an entity is a holding company or is otherwise exercising control of an insurer?
39. Should a holding company be permitted which is formed solely to hold stock in an insurance holding company?
40. Should contributions to held insurers be prohibited unless exchanged for value?
41. Should there be a prohibition or regulation against accommodation transactions such as accommodation deposits?

A general discussion of the problems involved was conducted and a series of statements were made by industry and organization representatives. Mr. Sam Cantor who served on the New York Holding Company Committee discussed the problems of studying holding companies and agreed to serve as an adviser to the Industry Committee.

Hon. Benjamin C. Neff, Jr., Chm., Neb.; Hon. Robert A. Short, Del.; Hon. Lorne R. Worthington, Iowa; Hon. C. Eugene Farnam, Mass.; Hon. Richard E. Stewart, N. Y.; Hon. Edwin S. Lanier, N. C.; Hon. James R. Faulstich, Ore.; Hon. David O. Maxwell, Pa.; Hon. Warren E. Dirks, S. D.; Hon. Durwood Manford, Texas.

To Make Recommendations, including drafting of Model Legislation  
if necessary, to regulate Long Term Credit Insurance

(D3) Subcom. Report (Mtg. 18)

The meeting of the (D3) Subcommittee was held in Ballroom B of the Portland Hilton Hotel on June 17, 1968 at 1:30 P.M.

The Chairman reported that the Industry Advisory Committee had held a number of meetings since its appointment, and had divided itself into three task forces to study the various types of long term loans and the kinds of insurance generally sold in connection with such credit transactions. He further advised that it had become apparent there were a number of problems involved which would require the assistance of actuaries and, perhaps, economists.

Some discussion was held concerning the advisability of amending the NAIC Model Bill providing for the regulation of credit life insurance and credit accident and health insurance.<sup>1</sup>

In Executive Session the Subcommittee authorized the Chairman and the Chairman of the Advisory Committee to secure the services of actuaries and such other experts as were determined to be necessary to continue to conduct the study. It was further pointed out that in the interim, problems continue to exist in a number of States with respect to so called "long term" transactions which might be dealt with by amending the Model Bill.<sup>1</sup> Accordingly the Subcommittee adopted a resolution recommending that the Laws and Legislation Committee consider the adoption of an amendment to Section 2 A (2) of the NAIC Model Bill to eliminate the current 5 year restriction but adding an exception for real estate first mortgage loan transactions. This amendment would be considered optional for the particular State. If so adopted, the language of the NAIC Model Code Section would read as follows:

"All life insurance and all accident and health insurance in connection with loans or other credit transactions shall be subject to the provisions of this Act, [except such insurance in connection with a loan or other credit transaction of more than five years duration;] *except such insurance as is written in connection with real estate first mortgage loan transactions;* nor shall insurance be subject to the provisions of this Act where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor."

Notes:

Matter in [brackets] had been deleted.  
Matter in *italics* has been added.

<sup>1</sup> 1961 Proc. Vol. I pp. 300-305

Note: NAIC Model Credit Bill added here for purposes of reference

Hon. William G. Walton, Chm., Wyo.; Hon. Allan W. Horne, Ark.; Hon. J. Richard Barnes, Colo.; Hon. Newton I. Steers, Jr., Md.; Hon. David J. Dykhouse, Mich.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. James H. Hunt, Vt.; Hon. Lee I. Kueckelhan, Wash.

References added:

- 1958 Proc. VOL. II p. 352
- 1959 Proc. VOL. I pp. 126-130
- 1959 Proc. VOL. II pp. 507-508
- 1960 Proc. VOL. I pp. 180-185
- 1960 Proc. VOL. II pp. 478-484 (Model Bill - Proposed Amendments)
- 1961 Proc. VOL. I pp. 300-305 (Model Bill as Amended - Adopted)

N.A.I.C. MODEL BILL TO PROVIDE FOR  
THE REGULATION OF CREDIT LIFE INSURANCE  
AND CREDIT ACCIDENT AND HEALTH INSURANCE

AS REVISED DECEMBER 1960

BE IT ENACTED BY THE STATE OF -----  
(adapt caption and formal portions to local requirements and statutes)

1. PURPOSE:

The purpose of this Act is to promote the public welfare by regulating credit life insurance and credit accident and health insurance. Nothing in this Act is intended to prohibit or discourage reasonable competition. The provisions of this Act shall be liberally construed.

2. SCOPE AND DEFINITIONS:

A. CITATION AND SCOPE

- (1) This Act may be cited as "The Model Act for the Regulation of Credit Life Insurance and Credit Accident and Health Insurance."
- (2) All life insurance and all accident and health insurance in connection with loans or other credit transactions shall be subject to the provisions of this Act, except such insurance in connection with a loan or other credit transaction of more than five years duration; nor shall insurance be subject to the provisions of this Act where the issuance of such insurance is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor.

B. DEFINITIONS

For the purpose of this Act:

- (1) "Credit life insurance means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction;
- (2) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;
- (3) "Creditor" means the lender of money or vendor or lessor of goods, services, or property, rights or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender, vendor, or lessor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them;
- (4) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction;
- (5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction;

(6) "Commissioner" means ----- (Insurance Supervisory Authority of the State).

3. **FORMS OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND HEALTH INSURANCE:**

Credit life insurance and credit accident and health insurance shall be issued only in the following forms:

- A. Individual policies of life insurance issued to debtors on the term plan;
- B. Individual policies of accident and health insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;
- C. Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;
- D. Group policies of accident and health insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

4. **AMOUNT OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND HEALTH INSURANCE**

A. Credit Life Insurance

(1) The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness and, where an indebtedness is repayable in substantially equal installments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

(Note: If desired the following provisions may be added as subsections (2) and (3).

- (2) Notwithstanding the provisions of the above paragraph, insurance on agricultural credit transaction commitments, not exceeding one year in duration may be written up to the amount of the loan commitment, on a non-decreasing or level term plan.
- (3) Notwithstanding the provisions of Paragraph A (1) of this or any other subsection, insurance on educational credit transaction commitments may be written for the amount of the portion of such commitment that has not been advanced by the creditor.

B. Credit Accident and Health Insurance

The total amount of periodic indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness; and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

5. **TERM OF CREDIT LIFE INSURANCE AND CREDIT ACCIDENT AND HEALTH INSURANCE:**

The term of any credit life insurance or credit accident and health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than thirty (30) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of such insurance shall not extend more than fifteen days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in Section 8.

6. PROVISIONS OF POLICIES AND CERTIFICATES OF INSURANCE:  
DISCLOSURE TO DEBTORS:

- A. All credit life insurance and credit accident and health insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.
- B. Each individual policy or group certificate of credit life insurance, and/or credit accident and health insurance shall, in addition to other requirements of law, set forth the name and home office address of the insurer, the name or names of the debtor or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor, the premium or amount of payment, if any, by the debtor separately for credit life insurance and credit accident and health insurance, a description of the coverage including the amount and term thereof, and any exceptions, limitations and restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to his estate.
- C. Said individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred except as hereinafter provided.
- D. If said individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for such policy or a notice of proposed insurance, signed by the debtor and setting forth the name and home office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and health insurance, the amount, term and a brief description of the coverage provided, shall be delivered to the debtor at the time such indebtedness is incurred. The copy of the application for, or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within thirty (30) days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificates of insurance to be delivered to the debtor. Said application or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in Section 5.
- E. If the named insurer does not accept the risk, then and in such event the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made.

7. FILING, APPROVAL AND WITHDRAWAL OF FORMS:

- A. All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this State and the schedules of premium rates pertaining thereto shall be filed with the Commissioner.
- B. The Commissioner shall within thirty (30) days after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders, disapprove any such form if the benefits provided therein are not reasonable in relation to the premium charge, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any provision of the Insurance Code or of any rule or regulation promulgated thereunder.
- C. If the Commissioner notifies the insurer that the form is disapproved, it is unlawful thereafter for such insurer to issue or use such form. In such notice, the Commissioner shall specify the reason for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider, shall be issued

or used until the expiration of thirty (30) days after it has been so filed, unless the Commissioner shall give his prior written approval thereto.

- D. The Commissioner may, at any time after a hearing held not less than twenty (20) days after written notice to the insurer, withdraw his approval of any such form on any ground set forth in subsection B above. The written notice of such hearing shall state the reason for the proposed withdrawal.
- E. It is not lawful for the insurer to issue such forms or use them after the effective date of such withdrawal.
- F. If a group policy of credit life insurance or credit accident and health insurance
  - (i) has been delivered in this State before the effective date of this Act, or
  - (ii) has been or is delivered in another State before or after the effective date of this Act,

the insurer shall be required to file only the group certificate and notice of proposed insurance delivered or issued for delivery in this State as specified in subsections B and D of Section 6 of this Act and such forms shall be approved by the Commissioner if they conform with the requirements specified in said subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the Commissioner; provided, however, the premium rate in effect on existing group policies may be continued until the first policy anniversary date following the date this Act becomes operative as provided in Section 12.

- G. Any order or final determination of the Commissioner under the provisions of this section shall be subject to judicial review.

#### 8. PREMIUMS AND REFUNDS :

- A. Any insurer may revise its schedules of premium rates from time to time, and shall file such revised schedules with the Commissioner. No insurer shall issue any credit life insurance policy or credit accident and health insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the Commissioner.
- B. Each individual policy, or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto; provided, however, that the Commissioner shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the Commissioner.
- C. If a creditor requires a debtor to make any payment for credit life insurance or credit accident and health insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account.
- D. The amount charged to a debtor for any credit life or credit health and accident insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

(Note: Where a state prohibits payments for insurance by the debtor in connection with credit transactions, the following paragraph may be included.)

- E. Nothing in this Act shall be construed to authorize any payments for insurance now prohibited under any statute, or rule thereunder, governing credit transactions.

#### 9. ISSUANCE OF POLICIES :

All policies of credit life insurance and credit accident and health insurance shall be delivered or issued for delivery in this state only by an insurer authorized to do an insurance business therein, and shall be issued only through holders of licenses or authorizations issued by the Commissioner.

**10. CLAIMS:**

- A. All claims shall be promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the insurance contract.
- B. All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of such claimant to one specified.
- C. No plan or arrangement shall be used whereby any person, firm or corporation other than the insurer or its designated claim representative shall be authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims; provided, that a group policyholder may, by arrangement with the group insurer, draw drafts or checks in payment of claims due to the group policyholder subject to audit and review by the insurer.

**11. EXISTING INSURANCE - CHOICE OF INSURER:**

When credit life insurance or credit accident and health insurance is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by him or of procuring and furnishing the required coverage through any insurer authorized to transact an insurance business within this state.

**12. ENFORCEMENT:**

The Commissioner may, after notice and hearing, issue such rules and regulations as he deems appropriate for the supervision of this Act. Whenever the Commissioner finds that there has been a violation of this Act or any rules or regulations issued pursuant thereto, and after written notice thereof and hearing given to the insurer or other person authorized or licensed by the Commissioner, he shall set forth the details of his findings together with an order for compliance by a specified date. Such order shall be binding on the insurer and other person authorized or licensed by the Commissioner on the date specified unless sooner withdrawn by the Commissioner or a stay thereof has been ordered by a court of competent jurisdiction. The provisions of Sections 5, 6, 7 and 8 of this Act shall not be operative until ninety (90) days after the effective date of this Act, and the Commissioner in his discretion may extend by not more than an additional ninety (90) days the initial period within which the provisions of said sections shall not be operative.

**13. JUDICIAL REVIEW:**

Any party to the proceeding affected by an order of the Commissioner shall be entitled to judicial review by following the procedure set forth in -----

**14. PENALTIES:**

In addition to any other penalty provided by law, any person, firm or corporation which violates an order of the Commissioner after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of ----- a sum not to exceed \$250.00 which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed \$1,000.00. The Commissioner, in his discretion, may revoke or suspend the license or certificate of authority of the person, firm or corporation guilty of such violation. Such order for suspension or revocation shall be upon notice and hearing, and shall be subject to judicial review as provided in Section 13 of this Act.

**15. SEPARABILITY PROVISION:**

If any provision of this Act, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of such provision to any person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

\* \* \* \* \*

To Make Recommendations, including drafting of Model Legislation  
if necessary, dealing with Unauthorized Insurers  
(D4) Subcom. Report (Mtg. 15)

The (D4) Subcommittee To Make Recommendations, including the drafting of Model Legislation dealing with Unauthorized Insurers met June 17, 1968 in Ballroom B of the Hilton Hotel, Portland. A quorum was present.

Upon review by Chairman Faulstich, Mr. Richard A. Edwards, Chairman of the Industry Advisory Committee presented the first report of such Committee. Mr. Edwards summarized the circumstances leading to the appointment of the Industry Advisory Committee, the mission of the Committee, the scope and organization of its first report, and the major principles set forth therein.

H. James Douds of the National Association of Life Underwriters reiterated his objections that part of the Industry Committee Report setting forth various exemptions to the requirement that all insurance transacted in a State must be transacted by a licensed insurer.

Mr. C. Malcolm Moss of the American Life Convention, Mr. John P. Hanna of the Health Insurance Association of America, and Mr. Eldon Wallingford of the Life Insurance Association of America, announced the concurrence of their respective organizations with the content of the first report.

Following a discussion of several points contained in the report, the Subcommittee went into Executive Session. In Executive Session the Subcommittee moved to receive the report of the Industry Advisory Committee and to express their appreciation for the work of that Committee to date.

It was also agreed to distribute the Industry Advisory Committee Report to all States with the solicitation of their comments and suggestions. It was further agreed that the Subcommittee will meet in Executive Session at a date in the near future to review comments and suggestions so received.

Hon. James R. Faulstich, Chm., Ore.; Hon. Frank M. Hogerty, Jr., Me.; Hon. Thomas C. Hunt, Minn.; Hon. Donald Knowlton, N. H.; Hon. Edwin S. Lanier, N. C.; Hon. David O. Maxwell, Pa.; Hon. Durwood Manford, Texas; Hon. Robert D. Haase, Wis.



The Honorable James R. Faulstich  
Commissioner of Insurance  
State of Oregon  
158 12th Street, N. E.  
Salem, Oregon 97310

Dear Commissioner Faulstich

In behalf of the Industry Advisory Committee for your NAIC Subcommittee (D4) to make Recommendations Dealing with Unauthorized Insurers, the First Report of such Committee is submitted herewith. Ten copies are enclosed to permit you to distribute copies, with your own transmittal letter, to the members of your (D4) Subcommittee. Additional copies are available upon your request, and copies will be available for the other Commissioners, their staff and industry representatives at the June 17 meeting of the (D4) Subcommittee.

The purpose of this First Report is to offer a series of recommended principles which, if acceptable to the Commissioners, will be translated into a final report and an accompanying model bill for submission to your (D4) Subcommittee prior to the December 1968 meeting of NAIC. Except for the minority report by Mr. Douds for the National Association of Life Underwriters (Appendix II), the recommendations contained herein represent the view of all members of your Industry Advisory Committee, but the interdependence of the recommendations is such that severance of one portion from the balance would create additional dissent.

In accordance with our discussion on May 2, our purpose in offering this First Report two weeks in advance of your meeting is to provide the members of your Subcommittee with ample time to consider the Report prior to their trip to Portland. This will permit nearly all but the Executive Session portion of your June 17 meeting to be used for questions and discussion, if you choose to follow such procedure. Nearly all members of the Industry Advisory Committee will be present at that time to answer questions which you or other Commissioners may have.

Respectfully submitted,

Richard A. Edwards  
Chairman, Industry Advisory  
Committee

cc: Members, Industry Advisory Committee  
June 4, 1968

FIRST REPORT  
OF THE  
NAIC INDUSTRY ADVISORY COMMITTEE  
ON UNAUTHORIZED INSURERS  
JUNE 4, 1968

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FIRST REPORT OF THE NAIC ADVISORY COMMITTEE ON  
UNAUTHORIZED INSURERS

I. HISTORY OF THE ISSUE

The definitive history of the unauthorized insurer problem is contained in a report submitted by George H. Kline, then Insurance Research Analyst for the New York Insurance Department and now General Counsel for the Allstate Insurance Company, to the June 1949 annual meeting of NAIC. An outline of such report and subsequent historical highlights is attached hereto for the convenience of the Commissioners. It is therefore unnecessary to recount Mr. Kline's findings. Copies of the Kline Report are virtually impossible to secure, and an additional two decades of activities have occurred since its preparation. Accordingly, your Committee believes it appropriate to begin this report with a brief enumeration of the inferences to be drawn from such history in order to place the problem in its modern perspective.

*First*, the printed *Proceedings* of the NAIC indicate that, except for surplus lines, virtually its total concern with the problem of unauthorized insurance has arisen from direct mail solicitation for health insurance (and, to some extent, life insurance) and indeed, within those areas, the quality of advertising employed. Such conclusion is illustrated, for example, by the very title of the Kline Report ("Regulation of Mail Order Accident and Health Insurance") and by the facts underlying the litigation which has occurred in this field.

*Second*, the history of the issue also shows a considerable measure of jurisdictional ambiguity and thus vacillation between the Federal Trade Commission and the regulation of insurance by the states as well as among the Committees of the NAIC. With respect to the latter, the NAIC *Proceedings* show a long history of efforts to resolve the problem within the NAIC Special Committee to Act As Liaison Committee with the Federal Trade Commission, the Unauthorized Insurers Committee, the Accident and Health Committee, the Executive and its Special Committee to Explore Jurisdiction of the FTC, the Federal Liaison Committee, the Preservation of State Regulation Committee, and the Laws and Legislation Committee and its Subcommittee to Study and Review State Insurance Laws and others. Although the foregoing Committee efforts have occurred in the past twenty years, the jurisdictional problem long antedates the Kline Report as is indicated in Parts IV and V thereof.

*Third*, since publication of the Kline Report, the decision in *Ministers Life and Casualty v. Haase*, 30 Wisc. (2d) 339, 141 N.W. (2d) 237, appeal dismissed, 385 U.S. 205 (1966), and *People v. United National Life Insurance Company et al.*, 58 Cal. Rptr. 599, 427 P. (2d) 199, appeal dismissed, ---- U. S. ----, 19 L. Ed. (2d) 562 (1967), have removed most of the earlier doubts as to the authority of a state to require licenses by direct mail insurers domiciled in another state. The most difficult legal problem which remains unresolved would appear to be the extent to which the Commissioner of one state may enforce his decisions against an insurer domiciled in another state. This problem is treated in some detail in Part V, Enforcement Procedures, of this report.

II. MISSION OF THE INDUSTRY ADVISORY COMMITTEE

The *Proceedings* of the NAIC indicate that the genesis for the appointment of the Industry Advisory Committee occurred in the June 22, 1966 report to the Advertising of Insurance Committee by the Subcommittee to Study NAIC-FTC Resolution. That report was concerned with the efficacy of the Resolution and, based upon a survey of the Commissioners concluded, inter alia, that complaints regarding unfair or deceptive advertising by unlicensed mail order insurers are widespread but are directed at only a few companies. The report also concluded that half of the states were considering the introduction of legislation similar to the Wisconsin unauthorized insurer law and that twenty-three states favor the enactment of either a model act or legislation similar to the Wisconsin or California statute.

At the December 7, 1966 meeting of the Advertising of Insurance Committee, upon recommendation by the Subcommittee to Study NAIC-FTC Resolution, the parent committee adopted a resolution that the states should take such steps as may be necessary and appropriate to prohibit the use of the U. S. mails (or other devices) to evade or avoid otherwise applicable state laws pertaining to regulation of insurance, and that an appropriate committee be instructed to draft recommendations, including legislation, dealing with activities of unauthorized insurers and report at the June 1967 meeting.

The President of the NAIC referred such resolution to the Laws and Legislation Committee which, at its June 14, 1967 meeting decided to appoint a Subcommittee on Unauthorized Insurers and an Industry Advisory Committee to consult and assist the Subcommittee in its research.

Such Subcommittee was appointed, with Commissioner James R. Faulstich as its Chairman. Its first meeting was held on December 4, 1967. At that time the Subcommittee recommended the establishment of an Industry Advisory Committee "to do necessary research relating to the regulation of unauthorized insurers" and to prepare "modern legislation in this area to be presented for final action by the National Association of Insurance Commissioners at their December 1968 meeting."

On April 26, 1968, the Industry Advisory Committee held its first meeting at which time, after extended discussion based upon historical and legal materials distributed to the Committee in advance of the meeting, it reached a series of conclusions as to the fundamental principles which should underlie remedial legislation. Those principles are set forth in Part III of this report.

On May 22, 1968, the Committee held its second meeting, the major purpose of which was to conduct a page-by-page discussion of an earlier draft of this report. The decisions reached are reflected in the text of this report.

### III. FUNDAMENTAL PRINCIPLES OF REMEDIAL LEGISLATION

The purpose of an unauthorized insurers regulatory act is to prohibit the transacting of insuring business within a state without a certificate of authority from the regulatory agency. Accordingly, the text must define what constitutes transacting an insurance business for purposes of the act, provide penalties for violation, protect the interest of policyholders and other parties involved in transactions with the unauthorized insurer, and provide procedures for enforcing the provisions of the act against the unauthorized company.

Recognizing that the main thrust of a model unauthorized insurers bill should be a prohibition of unlicensed direct mail solicitation. Safeguards are essential to protect the proper interests — not only of direct mail insurers — but more importantly their insureds. The application of indiscriminate prohibitions and penalties will jeopardize existing and valuable insurance rights, threaten the solvency of reputable companies, and set the stage for further litigation and regulatory controversy in this field.

#### A. Legislation Should Not Be Retroactive — Grandfather Clause to Permit Continued Servicing of Existing Contracts

Direct mail insurance companies for upwards of eighty years have had ample reason to suppose that their method of operations was a perfectly legal way of doing business and that such operations were subject to regulation and taxation only by the state of domicile.<sup>1</sup> This understanding was generally likewise held by the Insurance Departments of the various states. A substantial amount of such insurance has been sold and is now outstanding.

The language of some existing and proposed statutes prohibiting unauthorized insurers would affect existing policies by prohibiting the continued collection of premiums or other necessary administration of the policy of insurance held by residents of states in which the direct mail insurer is not licensed. Such a prohibition would result in extreme and unnecessary hardship both upon the hundreds of thousands of persons holding such policies and upon the companies that issued the policies. Many outstanding policies are guaranteed renewable or non-cancellable and contain other provisions of importance to policyholders. Advancing age, deteriorating health and other changing circumstances may preclude policyholders from replacing existing insurance or permit replacement only at higher premiums or other less favorable terms. Thus so far as the policyholders are concerned, the existing policies are valuable — perhaps irreplaceable — insurance rights.

So far as the companies are concerned, substantial time may be required to process license applications and, in some cases, corporate or capital structure may preclude licensing.

The proper objectives of state regulation would be achieved by the enactment and enforcement of state statutes prohibiting only future solicitation of new business by unauthorized direct mail insurers. It should be noted that the courts in both the

<sup>1</sup> *Allgeyer v. Louisiana*, 165 U.S. 578; *St. Louis Cotton Compress Co. v. Arkansas*, 260 U.S. 346; *Connecticut General Insurance Co. v. Johnson*, 303 U.S. 77; *Minnesota Commercial Men's Association v. Benn*, 261 U.S. 140; *National Bellas Hess v. Dept. of Revenue*, 386 U.S. 753.

*Ministers Life and Casualty*<sup>2</sup> and *United National*<sup>3</sup> cases were careful to preserve the enforceability of the existing policies issued to Wisconsin and California residents.

Retroactive application of taxes and penalties by the states to unlicensed direct mail insurers on account of past transactions may create serious problems. Retroactive application will, in some cases, involve amounts sufficiently large to threaten the solvency of the insurer and the stability of outstanding policies. In many instances, taxes have already been paid to the domiciliary state and cannot be fully recovered. In all cases the actuarial calculations have not taken into account the additional cost of penalties and of new or duplicative taxes. Insistence upon large payments in retroactive taxes and penalties may, therefore, preclude direct mail insurers otherwise qualified from seeking licenses in the states in which they are now unlicensed.

Attempts by the states to collect retroactive taxes and penalties from direct mail insurers by means of substituted service of process will be productive of additional litigation. This course of action will result in extended litigation to determine the extent to which the Supreme Court of the United States would, under these circumstances, require or permit enforcement of such judgments under the full faith and credit clause. Actions compelling such litigation would not serve the interests of the public, policyholders, state authorities or the insurers.

Imposition of penalties upon the direct mail companies for transactions involving policies written prior to the enactment of an unauthorized insurers statute would be unjust and would impose potential burdens of such magnitude as to jeopardize the existence of those companies to the obvious detriment of their insureds.

In order to prevent the retroactive application of a statute seeking to regulate unlicensed direct mail transactions, an exemption should be contained therein with respect to transactions involving policies in effect prior to the effective date of the model statute. In those states where unauthorized insurers statutes have already been enacted that do not contain the suggested "grandfather" exemption, the NAIC should recommend amendment of existing statutes to exempt from regulation and taxation those policies issued prior to the effective date of such amendment. Any other course would probably be productive of further litigation and uncertainty in this field and would undoubtedly prompt attempts to obtain intervention by the Federal government.

#### B. Prompt Action on Applications for Licenses and Other Administrative Action Necessary for Continued Operation by Direct Mail Insurers

The recent decisions in Wisconsin and California have sustained state power to require future direct mail solicitation of insurance to conform to regulation by the state in which the solicitation is received and circulated. A number of established direct mail insurers meet the standards of the states for admission and many of these companies will seek to obtain licenses in order to continue their business operations. It is in the interest of the public, the policyholders, and state regulation for the Commissioners to act promptly upon applications of these insurers for admission and to process promptly approval of policy forms, advertising, and other administrative action necessary for these insurers to continue their operations. It is recognized, of course, that a Commissioner may be bound by the standards imposed by the law of the state governing qualification of insurance companies. Nevertheless, it is important for the Commissioners to recognize that extensive delay can be tantamount to prohibition and will produce extensive damage to the insurer.

#### C. Resident Agent, Countersignature Provisions—Retaliation and Corporate Restrictions

There are a number of requirements imposed upon licensed insurers by the statutes of some of the states that have little or no regulatory purpose in the solicitation and sale of insurance by mail. Compelling direct mail insurers to obtain licenses confronts these insurers with very substantial problems. As early as 1949, the Kline Report identified a number of these requirements and suggested the importance of eliminating

<sup>2</sup> On December 5, 1966, the United States Supreme Court dismissed the appeal in *Ministers Life and Casualty Union v. Haase*, (30 Wis. 2d 339, 141 N.W. 2d 287) for want of a substantial federal question and denied a subsequently filed petition for rehearing. The effect of this dismissal was to sustain the decision of the Supreme Court of Wisconsin upholding the validity of a Wisconsin statute designed to regulate and tax unauthorized insurers transacting insurance by mail with residents of Wisconsin (Chapter 397, Laws of 1961, adding sec. 201.42 to the Wisconsin Insurance Code).

<sup>3</sup> On December 11, 1967, the United States Supreme Court dismissed for want of a substantial federal question an appeal in *United National Life Insurance Company, et al. v. California* (58 Cal. Rptr. 599, 427 P. 2d 199). In *United National*, the Supreme Court of California held that California could compel an unauthorized insurer to cease and desist from transacting insurance by mail with residents of California. The decision was based on the existing statutes of California and no specific statute outlawing mail order insurance was involved. The California court held that policies issued to California residents were valid contracts. The court injunction issued in the *United National* case permitted the defendant insurance companies to continue to collect premiums and otherwise administer policies previously issued to residents of California.

unnecessary barriers to the conduct of direct mail insurance operations if these insurers were required to obtain licenses in all states.

A review of such requirements and barriers led the Committee to discuss the justification and desirability of laws of some states which apply countersignature requirements to life and health insurance policies. Rather than suggesting limited exceptions in the laws based upon methods of merchandising, the Committee recommends that countersignature laws be inapplicable to life and health insurance. Such recommendation is consistent with the laws of most states.

In certain instances, the provisions of retaliatory statutes are thought to give rise to the necessity of prohibiting the licensing of a foreign company upon the grounds that the state of domicile would refuse to license a company of the state in which the license is sought. For reasons which are not readily apparent, some states forbid the licensing of companies solely upon the basis that they are chartered as a specific type of company, as for example, assessment companies, without regard to their actual method of operation, their maintenance of reserves, or their capital or surplus position.

#### D. Penalty Provisions Should Bear Some Reasonable Relationship to the Purpose Sought to Be Accomplished

The penalty proposed in any model bill should not be confiscatory. Sanctions should bear a reasonable relationship to the purposes to be achieved by the statute. Prohibition of unlicensed insurance operations must be justified by reference to the interests of the insured public. It is possible that policies might be written by a company in an unlicensed state without a willful intent to do so. Even in cases of violation, there remains the problem of serving the public interest while endeavoring to prevent further violation. Assuming hypothetically that a company has violated the statute to the extent of issuing one hundred policies upon which quarterly premiums are to be paid, the company will then be guilty of four hundred violations per year. If the penalty is mandatory and fixed at a rigid rate of \$2,500 per violation, it is apparent that a penalty totaling \$1,000,000 per year must be imposed if action is taken. The responsible Commissioner then finds himself on the horns of a dilemma. Enforcement will bankrupt the company to the obvious detriment of the insureds (to say nothing of the problems created for state regulation), while inaction will encourage further violation.

It is urged, therefore, that the penalty provision be permissive so that the Commissioner may determine the circumstances compelling action and further, that the amount of monetary penalties not be made mandatory.

### IV. AREAS OF NON-APPLICABILITY

- A. Group and Orphan Business. An unauthorized insurers law is designed to protect the interests of a state, its citizens and licensed insurers from the sale of insurance within that state by non-licensed insurers, and to make non-licensed insurers accountable for any such activities in the courts of that state. E.g., Minnesota Chapter 590 (H. 2260), Section 1, Laws 1967.

Such an unauthorized insurers law should include specific exemptions for orphan business and for group insurance transactions pursuant to contracts written outside the state.

The need for these exemptions results from the all-inclusive language in the definition of "transacting insurance business," which is defined so broadly that without these exemptions the unauthorized insurers law would far transcend its stated purpose. For example, the Minnesota law includes:

"(a) the issuance or delivery of a contract of insurance or annuity to a resident of this state; (b) the solicitation of an application for such a contract; (c) the collection of a premium, membership fee, assessment or other consideration for such a contract; or (d) the transaction of any matter subsequent to the execution of such a contract and arising out of it." Chap. 590, § 2(2), L. 1967.

In other words, "transacting insurance business" within the meaning of such statute would, without any exemptions, include each and every act done in that state beginning with the initial solicitation of a prospective insured up to and including the cashing of the final claim check by the ultimate beneficiary. In the case of orphan business and group insurance transactions pursuant to contracts written outside the state, this would be wholly inappropriate and impractical.

The orphan business situation generally arises when a person moves into one state, bringing with him an existing policy of insurance that was lawfully solicited, sold and delivered in another state in which the insurer was licensed to do business.

The insurer has no control whatever over the actions of its insureds, but if an insured moves into a state which has an unauthorized insurers law and in which the insurer is not licensed to do business, the insurer nevertheless must continue to keep the policy in force and is compelled to comply with its part of the contract so long as the insured pays the premium thereon when due. The insurer is not transacting insurance in that state in any real sense of the word, does not conduct its business in such a fashion so as to fall within the purpose of an unauthorized insurers law, but needs a specific exemption to avoid a technical violation of that law because of the broad scope of the definition of "transacting insurance business."

The group insurance situation is somewhat similar to the orphan business situation. For example, the master group policy is sold and delivered at the employer's place of business (usually his home office or his principal place of business), where the insurer must be licensed to do business. Certificates are thereafter issued by the employer to his employees. It may be that at the time of issuance of the master policy the employer has an office in another state in which the insurer is unlicensed, such as a sales office with as few as two or three employees in such other state. Even though the insurer knows this, it is patently unfair to limit or restrict the insurer's right to compete legally for business in one state by reason of the prospective purchaser's incidental activities in another state. Also, the situation may be that the employer conducts no activities in any state where the insurer is not licensed, but some employees covered by the master policy may live or subsequently move into such other state. In which event, the situation is virtually identical to the orphan business situation. Again, a specific exemption is necessary for this group insurance situation.

As is evident from the foregoing and as is well known by persons knowledgeable in the business, difficult and complex problems have arisen on various occasions in connection with proposals to apply extraterritorially the group laws of certain states to group insurance contracts crossing state lines. However, these are not the same as the problems of supervision, regulation and taxation of unauthorized mail order issuers. The two sets of problems, and the ramifications of proposed solutions of each, are separate and distinct. It is neither necessary nor advisable to attempt to solve all these alleged problems in one law.

Whether a company affirmatively seeks to do business in any given state is a management decision, and a mail order insurer by its actions has affirmatively so decided. Conversely, in the orphan business and group insurance situations, the insurer has not made such a management decision, and in fact may have considered the matter and for economy or other good reason decided not to enter a particular state. Such management decisions should not be legally forced upon an insurer merely by the geographical relocations or actions of its policyholders over which the insurer has no control. Therefore, an unauthorized insurers statute should include exemptions for these orphan business and group insurance situations.

These specific exemptions are included in most recently enacted unauthorized insurer statutes, and are phrased in several different ways. The phraseology used most frequently in 1967 and 1968 enactments is satisfactory, and is found in the Minnesota law which specifically exempts:

"(c) transactions in this state involving a policy lawfully solicited, written and delivered outside of this state covering only subjects of insurance not resident, located or expressly to be performed in this state at the time of issuance and which transactions are subsequent to the issuance of such policy; (d) transactions in this state involving group or blanket insurance and group annuities where the master policy of such groups was lawfully issued and delivered in a state in which the company was authorized to do an insurance business;" Chap. 590, § 2(1), L. 1967.

Thirteen states have enacted a group exemption like the one just quoted. It has been suggested, however, that in the alternative a nexus or situs requirement might be imposed. For example, the proposed model bill might limit the group exemption to situations in which the master policy is validly issued in and pursuant to the laws of a state in which the insurer is authorized to do an insurance business and in which the policyholder is domiciled or otherwise has a bona fide situs.

- B. Surplus Lines. The proposed model bill should not be applicable to surplus lines business which is subject to state law.

First, forty-nine of the fifty states now have separate laws dealing with surplus line business, and the other one (Delaware) has a bill under consideration. Many of these laws have been promulgated or modified during recent years so that it can be said that the surplus line business is controlled a great deal better today

than it was ten or twenty years ago. While the laws are not perfect, they go a long way towards protecting the public interest and providing markets where necessary, and also in protecting admitted insurers from unfair competition from unadmitted markets. The result has been that legitimate surplus line business can now be handled through the proper channels, with the states receiving the appropriate tax. As matters are working out satisfactorily with these existing surplus line laws, it would appear to be unwise for the proposed model bill to amend or even duplicate the present laws.

Second, and of great importance today, is the fact that with the increasing values and inflation of all types, capacity in both the property and casualty fields is an ever present problem for large industrial assureds. On many risks today total amounts of insurance required are unobtainable and it is necessary to solicit every possible foreign market that is financially responsible. It is therefore inappropriate for additional regulations or restrictions or extra costs to be imposed upon the surplus line business by the proposed model bill.

- C. Educational Institutions. Benefit plans are presently provided to non-profit educational and scientific institutions by stock and mutual insurers as well as limited purpose companies. These include retirement annuity and insurance contracts designed to meet the special requirements of the academic profession.

Contracts written for non-profit, tax-exempt educational and scientific institutions and their staff members ought to be excluded from the scope of coverage of the proposed unauthorized insurer act regardless of the nature of the insuring agency.

Educational and scientific institutions, both public and private, today are faced with nothing less than a financial crisis. At stake is their very survival. Therefore, the ability of these institutions to provide insured benefits plans at the lowest possible cost and at the least hindrance is vital.

Recognizing the special consideration arising from this line of business and the needs of educational and scientific institutions, some fourteen states have enacted unauthorized insurer laws which exempt companies engaged in servicing the academic world. To our knowledge no complaint has ever been voiced about the activities of these insurers. This exemption should be broadened to include all insurers who perform the same function and valuable service to education and science. The present exemptions have not frustrated the states in their effort to deal with the problems of direct mail insurance, and we do not believe that the broadening of these exemptive provisions will be subject to abuse.

- D. Reinsurance. The proposed model bill should not be applicable to reinsurance for two reasons.

First, it is well recognized that there is a capacity shortage in reinsurance markets for many property-casualty and liability coverages. The same problem arises in connection with the issuance of the very large policies of life insurance. Large amounts of reinsurance are available only when one uses the entire market capacity and there seems to be no need to restrict reinsurance facilities to admitted companies. Many of the professional reinsurers are admitted in most of the states, but larger risks are usually divided into parts and retroceded to a number of companies many of whom are not admitted in all of the states. It is in the public interest that large policies be issued quickly and efficiently. To do this requires access not only to a large number of United States companies, but to the international reinsurance market.

Second, reinsurance is negotiated between companies rather than members of the general public. The ceding and assuming parties do not need the benefit of additional regulatory protection. In fact they clearly need a continuance of the opportunity to exchange portfolios with as few fetters placed on the arrangements as possible. Rapidly rising insurable values require the maximum possible reinsurance capacity. Reinsurance whether supplied by admitted or unadmitted reinsurers is needed in order to maintain the largest available reinsurance market possible.

- E. Industrial Insureds. The purpose of regulation of insurance is not to have a controlled or regulated industry, but to protect the consumer. It would be to the consumer's advantage for industrial insureds to be exempt from the model bill.

First, the multi-state corporation finds it unduly restrictive to confine its insurance buying only to those companies which are admitted in all states. If Company "A" does business in ten states, and buys its insurance in its domicile, satisfying the domiciliary law should be sufficient, and it should not be precluded from buying from a company licensed there. Nor should it be hampered in pre-underwriting



inspections, loss prevention activities, or claims adjustments on assets in any state.

Second, the domestic company (unlike the individual whose insurance problems are merely those of one of many) may need custom-made coverage at custom-made rules to answer his unique problems. Such coverage may not be available from domestic insurers. He should be free to import such coverage into the state.

An exemption for industrial insureds would allow regulation for the protection of the individual consumer without harm to the corporate consumer.

- F. Ocean Marine. The Committee recommends that the proposed model bill not be applicable to ocean marine for three reasons.

First, marine insurance on vessels and their cargoes is essentially international in character, is subject to uncontrolled world competition and should, therefore, remain free and unfettered from local or national restrictions. This view is supported by the practical consideration that it is impossible to subject ocean marine insurance to strict local regulation. Because of its unique character, ocean marine insurance is generally exempt from the filing, rating, countersignature, unauthorized insurance and numerous other regulatory provisions of insurance codes of the various states.

Second, ocean marine insurance is customarily placed by experienced marine brokers and agents and such insurance may attach to risks at any place in the world and at any time. Marine underwriters will not always be in a position to know the exact route of a shipment nor in most cases is it possible for the insured to impart this information in advance to marine underwriters. It is important, however, for the protection of insureds that their marine underwriters be permitted to make inspections and surveys and adjustments under marine policies wherever the risk may be found and without fear of violating local regulations. On the other hand, marine insurers should be permitted free access to courts relative to matters arising under their policies without undue delay.

Third, for years the American Institute of Marine Underwriters has actively collaborated with similar associations of other countries in advocating at international trade and insurance gatherings of government officials and others throughout the world that ocean marine insurance and the commerce to which it is essential should necessarily be kept on a free competitive basis. Restrictive provisions in our laws governing the placement of ocean marine insurance are seized upon by foreign countries as justification for imposing restrictions upon American insurers.

#### V. ENFORCEMENT PROCEDURES

- A. Full Faith and Credit as Applicable to Injunctive Decrees. Article IV, Section 1, of the Constitution of the United States, provides in part: "Full Faith and Credit shall be given in each state to the public Acts, Records, and judicial Proceedings of every other State. And the Congress may by general laws prescribe the Manner in which such Acts, Records and Proceedings shall be proved, and the Effect thereof."

The Supreme Court has characterized the full faith and credit clause as a "nationally unifying force" which "altered the status of the several States as independent foreign sovereignties, each free to ignore rights and obligations created under the laws or established by the judicial proceedings of the others by making each an integral part of a single nation, in which rights judicially established in any part are given nation-wide application," *Magnolia Petroleum Co. v. Hunt*, 320 U. S. 430, 439 (1943). Such a view, offered in an opinion concerned with the "nation-wide application" of judgments founded upon workmen compensation awards, would be even more appropriate as applied to efforts of the various States to discharge their responsibilities under the McCarran-Ferguson Act.

The Committee has reviewed the "Memorandum of Authorities for [the] Subcommittee on Mail Order and Unauthorized Insurance Companies", dated October 2, 1950, in which an All Industry Committee addressed itself to the enforceability of injunctions under the full faith and credit clause. Such memorandum reviews instances in which equitable decrees other than injunctions have been accorded full faith and credit, and concludes with an opinion on the application of the full faith and credit clause to injunctions: "The lack of guiding precedent in this field makes hazardous the enunciation of very positive opinions about what the Supreme Court will do in fact. On the other hand, the absence of contrary authority against faith and credit, persuasive policy arguments in favor of enforcement, and the general tendency of the Supreme Court to expand the area of full faith and credit,

do indicate that the chances of a favorable holding are good." *Proceedings of the NAIC* (Eighty-second session, 1951), p. 179.

Since the October 1950 Report, the Supreme Court of the United States has not had an occasion to give definitive recognition to the legal status of foreign equitable decrees. It is therefore impossible to give assurance that injunctions rendered in one state, under the proposed model unauthorized insurers statute, would be entitled to enforcement in other states. Indeed, there is a danger that the courts of one state would not even entertain an action founded upon an injunction decree of another state. "Since, ordinarily, an action cannot be maintained on a valid foreign judgment that defendant do or refrain from doing an act other than the payment of money, the judgment or decree must also be for the payment of money, and must be of a nature to create a definite, absolute, and unconditional indebtedness against defendant . . ." 50 *Corpus Juris Secundum*, Judgments, #868a. "A valid foreign judgment that the defendant do or refrain from doing an act other than the payment of money will not be enforced by an action on the judgment." *Restatement of Conflict of Laws* (St. Paul: American Law Institute, 1934), Sec. 449 (1). Accord: *McQuillen v. Dillon*, 98 F. (2d) 726, 729 (1938), cert. denied, 305 U.S. 655 (1938); *Burke v. Burke*, 32 Del. Ch. 320, 325 (1952). "No right created by a valid judgment, except a judgment for the payment of money, will be enforced in another state by action on the judgment." *Restatement of Conflict of Laws*, Sec. 447.

The foregoing jurisdictional principle is of such force that there are very few recorded decisions on the constitutional issue — i.e. whether an injunction decree is entitled to full faith and credit in the courts of a sister state. Those few decisions suggest a negative answer to the issue. For example, in *Union Pacific Railway Company v. Ruld*, 155 Minn. 302 (1923), a final decree, rendered by a court of general jurisdiction in F-1 permanently enjoining A, a citizen thereof, from maintaining and prosecuting a tort action in F-2 against B, was held not entitled to full faith and credit in F-2.

The Industry Advisory Committee is of the opinion that the proposed model bill should contain a provision for injunctive enforcement as one of the remedies available to the Commissioner. If a future decision of the U. S. Supreme Court extends full faith and credit obligation to injunctions, it would not be necessary to amend the model bill to add such enforcement procedure. If, on the other hand, the Court rules to the contrary, the Commissioner would still have the other remedies described below available to him.

- B. Full Faith and Credit as Applicable to Money Judgments. The draftsmen of any model bill pertaining to unauthorized insurers which is to include enforcement provisions in the form of money damages, based upon an insurer's failure to obtain a license to do business in the state prior to its performance of any act which is among those listed in the bill as constituting the doing of an insurance business, must take into account the existing Supreme Court decisions bearing upon the so-called penal exception to the requirement of the full faith and credit clause of the United States Constitution and its implementing statute. Obtaining such a judgment in its courts will avail the state little, insofar as serving as a deterrent to further such actions by an unauthorized insurer, if the state of domicile of the insurer will not give such judgment full faith and credit.

The two significant United States Supreme Court decisions on this subject are *Huntington v. Attrill*, 146 U.S. 657 (1892) and *Milwaukee County v. M. E. White Company*, 296 U.S. 268 (1935). In the *Huntington* case a bill in equity was filed by Mr. Huntington in a Baltimore court in an attempt to have set aside a transfer of stock which Mr. Attrill had allegedly made to his wife and daughters in fraud of his creditors and to charge such stock with the payment of the judgment recovered by Huntington against Attrill in New York upon the latter's liability as a director of a New York corporation under a statute imposing liability on a corporate director to creditors for a false affidavit with respect to the amount of paid-in-stock. When the case was taken to the Supreme Court on writ of error following a refusal of the Maryland court to enforce the New York judgment on the grounds that the statute was penal in nature, the Supreme Court reversed the Maryland decision, stating that the test as to whether or not a statute is penal, in the international sense, depends upon whether the purpose of the law is "to punish an offense against the public justice of the state, or to afford a private remedy to the person injured by the wrongful act." 146 U.S. 657, at 673-674. This test would appear to constitute such a narrow definition of the term penal as to make it "substantially synonymous with 'criminal'." *The Constitution of the United States of America, Analysis and Interpretation*, prepared by Legislative Reference Service, Library of Congress (1964), p. 763. Under this test, it would

appear that a judgment for a fine for violation of such a statute would be deemed to be penal and would not be entitled to full faith and credit.

The *Huntington* case did not really constitute a decision that a penal judgment was not entitled to full faith and credit, holding only that the New York statute was not penal and thus entitled to full faith and credit. "Presumably, this so-called exception was established in the earlier case of *Wisconsin v. Pelican Insurance Company*, 127 U.S. 265 (1888)," and was based on the concept that "the courts of no country execute the penal laws of another . . .," first expressed in this country by Chief Justice Marshall in *The Antelope*, 23 U.S. (10 Wheat.) 337, 344 (1825). See Hanson and Obenberger, *Mail Order Insurers: A Case Study in the Ability of the States to Regulate the Insurance Business*, *Marquette Law Review*, Vol. 50, No. 2, 175, at 284.

However, as pointed out by the United States Supreme Court in *Fauntleroy v. Lum*, 210 U.S. 230 (1903), and by Messrs. Hanson and Obenberger, the *Pelican* case involved a suit invoking the original jurisdiction of the Supreme Court and the applicability of the full faith and credit clause to a suit in a state court on a judgment rendered in another state was not in issue, so that the statements in the *Pelican* case may be regarded as mere dictum.

Although foreign revenue laws have generally been classified together with penal laws in this respect, the Supreme Court, in 1935, in the *Milwaukee County* case, required that full faith and credit be given to the judgment of another state for taxes, even though it included what it referred to as "a nominal penalty" of 2% for delinquency in payment. In reaching this decision the Court stated that the record did not disclose whether this nominal penalty arose under a penal law and appeared to assume that it did not. Since the judgment which it was requiring to be enforced was "stated to be for taxes," the court did not have to make any decision with respect to whether or not a judgment for a penal sum would be entitled to full faith and credit. The Court stated that ". . . the obligation to pay taxes is not penal. It is a statutory liability, quasi-contractual in nature . . ." 296 U.S. 268, 271. The defendant in this case had relied upon the following sentence in the *Pelican* case:

"The essential nature and real foundation of a cause of action are not changed by recovering judgment upon it, and the technical rules, which regard the original claim as merged in the judgment, and the judgment as implying a promise by the defendant to pay it, do not preclude a court, to which a judgment is presented for affirmative action, (while it cannot go behind the judgment for the purpose of examining into the validity of the claim) from ascertaining whether the claim is really one of such a nature that the court is authorized to enforce it." 127 U.S. 265, 292-293.

The Court in the *Milwaukee County* case disagreed with this, stating:

"So far as the opinion can be taken to suggest that full faith and credit is not required with respect to a judgment unless the original cause of action would have been entitled to like credit, it is inconsistent with decisions of this court . . ." 296 U.S. 268, 278.

In view of the above, it would appear that we can safely say that considerable doubt has been cast by the *Milwaukee County* decision upon the penalty exception and that, in an appropriate case today, the Supreme Court might well decide that there is no longer any real need for its continuance insofar as money damages are concerned. Messrs. Hanson and Obenberger, in the article referred to above, recommend that a test case be instituted for the purpose of trying to achieve this result. The chances of success of such an endeavor would appear to be quite good, for, as stated in the *Milwaukee County* case, "the very purpose of the full faith and credit clause was to alter the status of the several states as independent foreign sovereignties, each free to ignore the obligations created under the laws or by the judicial proceedings of the others, and to make them integral parts of a single nation throughout which a remedy upon a just obligation might be demanded as of right, irrespective of the state of origin." 296 U.S. 268, at 276-277.

In any event, such a model bill should include provision for the payment of a considerable sum, perhaps some amount somewhere between \$100 and \$1,000, for it to constitute a meaningful deterrent to the continuance of an unauthorized insurer of such activities. An alternative approach is that of wording the requirement for the payment of such a sum by reason of having done within the state one of the acts listed as constituting the doing of an insurance business therein, in terms, not of a penalty, but of a consideration for the privilege which has been given by the state for the performance of such an act. In the *Milwaukee County* case the following statement was also made:

"In a suit upon a money judgment for a civil cause of action the validity of the claim upon which it was founded is not open to inquiry, whatever its genesis. Regardless of the nature of the right which gave rise to it, the judgment is an obligation to pay money in the nature of a debt upon a specialty." 296 U.S. 268, at 275.

Following the decision in the *Milwaukee County* case a change was made in the wording of Section 443 of the Restatement of Conflict of Laws of the American Law Institute. Prior to the change it read as follows:

"A valid foreign judgment for the payment of money which has been obtained in favor of a state, a state agency, or a private person, on a cause of action created by the law of a foreign state as a method of furthering its own governmental interests will not be enforced."

After the *Milwaukee County* decision the words "will not be enforced" were deleted and the following inserted in their place:

"... will be enforced unless it is deemed to be a penalty."

Restatement Commented on this new wording reads as follows:

"A valid foreign judgment for the payment of money which has been obtained in favor of a state will be enforced if it is based upon a claim for a privilege given or for services rendered by the state for a price, or if it is based upon a tax claim, since such claims are not deemed penalties.

Thus, it would seem that the desired result might well be achieved by such a change in terminology. While there can be no certainty as to this, there would seem to be at least the probability that a judgment by a state for such a "consideration" might well be deemed entitled to full faith and credit even if the penalty exception itself is not overruled.

- C. A Statutory Alternative to Full Faith and Credit: Reciprocal Judgment Provisions. The essential uncertainty of current case law with respect to the ability of an Insurance Commissioner to enforce either monetary penalties or injunctions against an unauthorized insurer under the full faith and credit clause of the Constitution, as discussed in Parts A and B of this section, makes it mandatory that we consider alternative methods of granting to a Commissioner the power he needs to make any suggested model bill a workable tool. One possible alternative, which was contained in the Kline report, was the enactment of a law by Congress which would make the United States District Courts available for suits brought by a Commissioner against an unauthorized insurer. Our Committee decided that, while this avenue was open to us, it would be far preferable to solve the problem through state action.

The other alternative discussed was the possibility of adding language to the model bill which would automatically make the court processes of the enacting state available to the Insurance Commissioner of another state on a reciprocal basis. That is, if States A and B each had enacted the model bill, the courts of State A would be available to the Commissioner of State B to enforce monetary judgments or injunctions rendered in State B against an insurer domiciled in State A. In like manner, the courts of State B would be available to the Commissioner of State A for the purpose of enforcing the model bill. Of course, the NAIC's Unauthorized Insurers Service of Process Act would have to be in effect in each such state in order to obtain jurisdiction over the unauthorized insurer in the first instance.

Such an approach has been suggested in an article on mail order insurers by Jon S. Hanson (recommended to become Research Consultant to the NAIC) and Thomas E. Obenberger which appeared in the November, 1966 edition of the *Marquette Law Review*. The approach suggested by Messrs. Hanson and Obenberger is itself, as noted in the article, derived from the Uniform Enforcement of Foreign Judgments Act which was adopted by the National Conference of Commissioners on Uniform State Laws in 1964.

The approach and the draft legislation suggested by Messrs. Hanson and Obenberger, in effect, grants, by state legislation, full faith and credit to foreign judgments against a domestic insurer, whether the action was brought by the regulator, the insured or a beneficiary. Since we are considering this alternative within the regulatory context, it would be best to make any suggested legislation available only to the insurance regulators. This would give us consistency with our approach to the central problem. This also has the practical benefit of permitting us to merge such a statutory approach into the model bill which the Committee is to consider,

thereby requiring enactment of only one bill. Insureds and beneficiaries would not seem to require assistance here, since the full faith and credit clause of the U. S. Constitution, and its interpretation by the courts, does not appear to present the same problems facing regulators with respect to penalties and injunctions.

#### VI. CONCLUSION

The foregoing report is offered to the NAIC Subcommittee (D4) to make recommendations dealing with Unauthorized Insurers in order to facilitate its decisions upon policy matters prior to efforts by the Industry Advisory Committee to translate such decisions into a suggested model bill. That step will be taken, if the (D4) Subcommittee so desires, between the June and December 1968 meetings of the NAIC.

Respectfully submitted,

Richard A. Edwards,  
Chairman,  
Industry Advisory Committee

on behalf of

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APPENDIX ONE:

THE HISTORY OF THE UNAUTHORIZED INSURER PROBLEM

Before the

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Part I: 1880-1949 — An Outline of The Kline Report

Part II: 1949-1967 — A Summary of NAIC Actions and Studies

By Joe W. Peel

Assistant General Counsel

Health Insurance Association of America

PART I

OUTLINE OF

REGULATION OF MAIL ORDER

ACCIDENT AND HEALTH

INSURANCE

By

George H. Kline

Insurance Research Analyst

New York Insurance Department

(Submitted to NAIC at June 1949 Annual Meeting)

(Noted in "Proceedings" NAIC 1949, page 499)

- I. PURPOSE OF STUDY (Cover letter by Superintendent Robert E. Dineen dated June 1, 1949.)
  - A. Summary of problems presented by unauthorized mail order insurers.
  - B. Summary of accomplishments of states to regulate.
  - C. To provide assistance to industry and regulatory groups in reaching conclusions and formulating recommendations.
- II. THE UNSOLVED PROBLEM
  - A. Purchase of mail order policies from companies not licensed in state of insured's residence.
    1. Policies have restrictive benefits.
    2. Companies not "doing business" in state, in a restricted legal sense, since have no representatives in state and may not be sued.
  - B. How is such business obtained.
    1. Prospects secured through advertisements in newspapers and periodicals or direct mail campaigns based on purchased mailing lists.
    2. Sale made by mail and policy forwarded through mail.
  - C. Position of Policyholder.
    1. Acceptance without realizing limitations and is lulled into false sense of security.
    2. Upon realization of limitations, usually at claim time, complaints are voiced.

- D. What can be done by Complainant's Insurance Department.
1. Correspondence with company.
  2. Refer policyholder to Commissioner of state of company's domicile or refer complaint to such Commissioner.
  3. Effectiveness of methods difficult to predict and varies.
- E. Classifications of Insurance.
1. "Authorized" insurers defined as those licensed in every state from which derive substantial amount of total direct premium volume. Applies not only to companies licensed in all states but also to those licensed in one or a few states where they confine major activities.
    - a. Such business as they have in states where not licensed is either reinsurance or
    - b. Direct writings which are incidental only, such as renewals on policies whose holder has changed residence, or
    - c. Incidents of interstate contracts embracing risks of a multifocation or transitory nature.
  2. "Unauthorized" insurers categorized as
    - a. Criminals operating on fraudulent basis. Study not concerned with these since they are subject to prosecution by both local and federal authorities under existing statutes against larceny, fraud, illegal use of mails and licensing statutes.
    - b. Companies licensed in one or a few states but either unable or unwilling to comply with licensing requirements in other states where propose to do business. Have no agents or officers in such states; solicit business by mail and advertising originating in state where licensed. Accident and health has received most attention, however, life, fire and auto insurance is sold by same means. This study chiefly concerned with accident and health.
    - c. Nothing inherently harmful or immoral in sale of insurance by mail. Many responsible companies with worthwhile coverage at reasonable rates sell and service coverage by mail without licensing other than in state of domicile. Absence of license in all states does not make a dishonest operation out of an honest business. Licensing alone does not constitute complete assurance of ethical responsibility. All "mail order" companies are licensed in at least state of domicile.
- F. Telling the Bad from the Good.
1. Many mail order companies whose practices are highly commendable; others are a disgrace to the business.
  2. Companies which have earned general condemnation usually have several of following characteristics:
    - a. Qualification in domiciliary state only; generally, in which insurance department is handicapped by inadequate powers, limited funds or local politics.
    - b. Specialization in A & H, hospital, or sometimes life policies of extremely limited type, issued for small premium.
    - c. Flamboyant advertising which, if not actually fraudulent, is deceptive and misleading and aimed at most gullible segments of public.
    - d. Inadequate financial resources for volume and character of business.
    - e. Low loss ratios and high expense and profit ratios as to indicate inferior product, although ratios of this type may reflect good underwriting or favorable economic conditions.
    - f. Sharp claim practices.
    - g. Avoidance of customary sales methods and use of large scale direct mail campaigns.

- h. Difficulty in securing operating and financial data on such insurers through reputable private insurance reporting agencies.

G. Size of the Problem.

1. A & H insurance a vast business. Practically all complaints against mail order insurers center around activities of small number of irresponsible concerns, accounting for small portion of all premium.
2. Concrete statistical data almost completely lacking as to how much money, people and companies involved.
  - a. Partial statistics indicate (New York, 1947) 6.4% of individual A & H premium written by mail order companies. Probably much less than half written by irresponsible insurers.
  - b. Problem created by these carriers out of proportion to their number or amount of business.
3. Regrettable indictment of Government if sharp practices of few could not be handled without imposing burdens of further controls upon entire A & H industry.
4. More extensive regulation does not automatically bring reform. Some will always take chance of getting caught and making peace with any regulatory system. Their hope of reward is stimulated by existence of element in public who will be fooled despite every effort of government to protect them.

III. ACCIDENT AND HEALTH REGULATION EVOLVES

A. Early Development of A & H Insurance.

1. Guilds; Friendly Societies in England; Trade Unions.
2. Societies formed in U. S. as early as 1845.
3. Trade Associations 1891.

B. A & H Regulation Grows.

1. Founding of State Regulation of Insurance; *Paul vs. Virginia*, 1868.
2. Founding of NCIC 1871.
3. A & H originally subject to general state regulatory laws. Early recognition of differences from other lines and presented special regulatory problems.
4. Standard Provisions Law of 1912.
  - a. First Uniform A & H Policy Provisions Bill. Adopted by NCIC.
  - b. Adopted in 25 states (1949).
  - c. NAIC study of law beginning in 1945 for possible revision or new legislation.
5. The Official Guide.
  - a. Developed by NAIC as necessary adjunct to Standard Provision Law; experience gained in administration of law. Purpose to gain greater uniformity in interpretation and regulation.
6. Accident and Health Experience Reporting Form.
  - a. Study by NAIC beginning in 1945 to obtain information on loss ratios by lines of A & H business.
  - b. Form adopted in 1948 to make available experience data to enable regulatory officials to determine whether particular policies provide benefits commensurate with premium charged. (Developed in conjunction with following item.)
7. Accident and Health Regulatory Law; Filing and Approval of Forms.
  - a. NAIC Committee studies to devise methods for coping with misleading and restrictive A & H policy forms (*Proceedings*, NAIC 1947, pp. 172 and 213.)



- b. Exploration of including A & H under rate regulation along lines of property and casualty insurers. Rejected by NAIC due to peculiarities of business.
  - c. Developed special model legislation requiring filing and approval of policy forms and providing for withdrawal of approval of forms where Commissioner finds that benefits provided are unreasonable in relation to premium charged. (*Proceedings*, NAIC 1947, pp. 213-219.)
    - (1) Not to be construed as "rate regulation."
    - (2) To provide Commissioner with tools to cope with competitive factors which do not always lead to issuance of policies desirable from public standpoint.
8. Minimum Benefits.
- a. Standard Provisions Law not designed to cover benefits.
  - b. NAIC consideration of legislation requiring minimum benefits. (Later rejected.)
9. Unfair Trade Practices.
- a. Model legislation developed by NAIC in 1947. (*Proceedings*, NAIC 1947, pp. 300-413.)
  - b. Adopted in 23 states (1949).
10. Other.
- a. Multiple state advertising studies by NAIC.
  - b. Statement of Principles (1948).

#### IV. UNAUTHORIZED INSURANCE: A JURISDICTIONAL PROBLEM

A. Unauthorized insurance not a new development. Mention made of problem as early as 1855.

1. NCIC appointed committee in 1880's to deal with question.
2. In 1895, NCIC recommended each state pass a law prohibiting domestic companies from doing business in any state where not authorized.
3. 1902-1907, NCIC memorialized Postmaster General and Congress. Committee appeared before Congress. Unauthorized Insurance Committee recommended individual Commissioners revoke charters of offending companies.
4. In 1914, North Carolina recommended: (a) Federal requirement that companies prove safety and solvency before allowed to use mails; (b) State supervision to prevent domestic companies from doing business in states where not licensed; (c) Legislation to require assured's to retain portion of premium on policies issued by unauthorized companies and remit same to home states.
5. Laws and Legislation Committee recommended bill patterned after 1895 suggestion. (See 2. above.)
6. In 1928, suggested each state pass law penalizing its own companies for accepting risks from any state where not licensed providing latter state had similar law. Unauthorized Insurance Committee noted jurisdictional problem to effect that state of domicile had power to act while state of insured's residence is powerless. (*Proceedings*, NCIC 1928, pp. 105-106; 134.)

#### B. The Hobbs Bill.

1. Introduced by Congressman Hobbs of Alabama in 1935. Would have prohibited use of U. S. Mails by any insurer to solicit or transmit policies or collect premium, except renewal premium for life and A & H policies, unless insurer first complied with insurance laws of state where contracts are solicited, negotiated or effected. Would not have applied to newspapers, magazines or periodicals of general

circulation or contracts of reinsurance. Provided for fines up to \$5000, imprisonment up to 2 years or both and would have been enforced by Justice Department.

2. Bill had effect of a compulsory licensing proposal.
3. 1935 bill supported by number of Commissioners; opposed by interested segments of insurance industry. (Specific objections noted below.)
4. Bill died in Committee in 1935. Reintroduced in 1941; opposed by NAIC Executive Committee and was defeated. Similar fate in 1943.

C. Uniform Unauthorized Insurers Act.

1. NAIC, in 1936, informed that ABA was preparing uniform bill and referring it to National Conference of Commissioners on Uniform State Laws. Act approved by Conference in 1938.
  - a. Prohibited acting as agent in state for unauthorized insurer or acting for insured in placing or effecting unauthorized insurance. Excepted reinsurance contracts, risks covering transportation and navigation, investigation and adjustment of losses or compliance with contracts made in state where insurer was authorized and surplus lines.
  - b. Provided for substituted service of process by insured on Commissioner of Insurance or person soliciting in state.
2. NAIC did not concur in ABA bill; believed it to be inadequate.
  - a. 1941 NAIC Laws and Legislation Committee recommended "Reciprocal Licensing Law."
    - (1) Provided that Commissioner shall revoke license of any domestic insurer found to have transacted or attempted to transact business in any jurisdiction in which insurer is not licensed; provided, not applicable when major portion of risks originated in jurisdiction where insurer was licensed and origin was by other means than circularization or advertising locally.
    - (2) "Transacting business" defined as including advertising and circularizing in state where not licensed for purpose of soliciting business.
  - b. By 1943, six states had enacted bill.
3. California enacted different law based on reciprocity in 1941.
  - a. Section 706-7. Defines reciprocal state as state which prohibits domestic insurer from insuring lives or property in California unless licensed in California.
  - b. Permissible exceptions in other state law: contracts entered into where applicant personally present in state where insurer is licensed and where he signs application; issuance of certificates under lawfully transacted group life or group disability policy where master policy was entered into in a state where insurer was licensed; renewal or continuance in force, with or without modification of contracts otherwise lawful and which were not originally executed in violation of section.
  - c. Subject to exceptions, domestic California insurer, shall not enter into contracts of insurance in a reciprocal state unless licensed in such state.
  - d. Commissioner to notify domestic insurers, annually, of the reciprocal states.

D. The Turning Point.

1. *U. S. vs. Southeastern Underwriters Association*, 332 U.S. 533 (1944).
2. Public Law 15.
3. Effect on unauthorized insurer problem.

## V. WHICH WAY

At least 3 different philosophies for coping with unauthorized insurers problem have evolved.

- A. Utilize existing state powers. (See VII below)
  1. State penal powers.
  2. State licensing powers by state of domicile.
  3. State judicial power.
  4. State tax powers.
  5. State powers over advertising.
  6. State utilization of original jurisdiction of U. S. Supreme Court.
- B. Federal Legislation in Aid of State Powers. (See VIII below)
  1. Postal Power.
  2. Judicial Power.
  3. State Cooperation with Post Office Department.
- C. Federal Trade Commission.
  1. State measures inadequate.
  2. FTC is logical agency to have jurisdiction.

## VI. A BASIS FOR SELECTION

Presence of many varied proposals presents problem of selecting one alternative or integrating many solutions into one consolidated approach. Decision must be made on basis of evaluation to consist of sufficient number of specific items to permit accurate appraisal of merits of each plan.

- A. The Qualitative Factors Involved.
  1. Legality and Constitutionality. Obviously must be constitutional. Must review nice points of constitutional law and Supreme Court interpretation.
  2. Jurisdiction. Connected with constitutionality but merits separate treatment. If state seeking to regulate cannot obtain some form of jurisdiction over unauthorized insurer, enforcement cannot be sustained.
    - a. *In personam* jurisdiction is primary requisite since will permit state to effectively enforce decrees or decisions at least in own state courts.
    - b. *In rem* jurisdiction does not answer problem. Except in extraordinary situations, unauthorized insurers do not have property in state.
  3. Enforcement. Might be necessary to sue on judgment obtained in policyholders state in court of state of domicile of insurer. Raises legal problem under full faith and credit clause of U. S. Constitution.
    - a. Operational Effect. Two distinct aspects:
      - (1) Provision of redress to private litigants;
      - (2) Action by states to punish and prevent further abuse by same insurer;
      - (3) Solution to first appears almost completely retrospective in that it would supply remedy after event, but no practical bar to recurrence; solution to second would be remedy either retrospective in operation (application of criminal penalty) or prospective (use of injunctive process). Most desirable method is one which will permit prospective operation since will serve to prevent recurrences.
    - b. Speed and certainty. Necessity for in any in method of control.

- (1) Should not require long preparation of case.
- (2) Should be capable of rapid processing by courts.
- (3) Should afford state opportunity to obtain temporary relief, pending adjudication. Possibility of obtaining injunctive or similar relief should be regarded as desirable feature.

c. Selectivity.

- (1) Hearings on Hobbs bill made clear that legitimate mail order companies will oppose, with justice, procedures which compel all companies to use certain marketing methods only, such as agency system.
- (2) Element of selectivity in regulatory plan, would avoid this objection and permit Commissioner to proceed against undesirable companies without hampering operations of legitimate insurers.

d. Practicality.

- (1) Plan must be practical if to achieve worthwhile results. Even though appears meritorious on its face, if not workable in light of every day operation, should be discarded.
- (2) Remedy should allow Commissioner to take action on own motion.

VII. UTILIZATION OF EXISTING STATE POWERS

A. Use of Criminal Laws to Make Certain Practices Felonies.

- 1. Legality and Constitutionality. State has power to punish acts committed outside borders which result in injury or unlawful results in state.
- 2. Whether use of U. S. Mails as instrumentality for crime changes above rule has never been decided by courts although there is dicta in U. S. Supreme Court to effect that use of mails should not change net result. So held in state court in *Travelers Health vs. Virginia*.
- 3. Due Process of Law.
  - a. Problem of obtaining jurisdiction over person of the offender.
  - b. Extradition raises serious question of whether officers of insurer can be extradited since legal foundation for extradition assumes offender was present when crime committed. In mail order cases, officer was never present in state.
  - c. Even though Uniform Criminal Extradition Act removes requirement noted in b., it does require that for act to be extraditable, it must have been an unlawful act in both state where act occurred and in state to which application is made for extradition. Would require uniform unauthorized mail order laws to be passed, which presents another problem.
  - d. Extraditable crimes limited as practical matter to felonies.
- 4. Operational Effect.
  - a. Criminal penalties would provide private persons opportunity for venting honest wrath at those who had defrauded and state would gain redress for offenses.
  - b. Application of criminal sanctions to officers of one company would have salutary effect upon others. Exact extent of influence difficult to predict. If only dealing with legitimate area, criminal conviction would have respect.
  - c. Corollary aspect of problem is actual legal effect, which is that criminal laws can only be retrospective in operation. Punishment is for what has been done, rather than preventing recurrences.
- 5. Speed and Certainty.
  - a. Criminal penalty method is reasonably rapid when consideration is given to amount of preparation required for each case.

- b. Each violation is basis for new prosecution.
  - c. Criminal enforcement agencies usually well qualified to prosecute, along with assistance from Insurance Department.
  - d. Speed of prosecution differs in every state.
    - (1) Grand jury system can be cumbersome.
    - (2) Crowded court calendars.
  - e. Method has serious practical disadvantage of requiring uniform
6. Selectivity.
- a. Not selective; what is crime for one is crime for all.
  - b. Would affect legitimate companies as well as irresponsible.
  - c. Although legitimate operators might not need be concerned with fraud, realistically, would force such insurers to submit advertising to all states in which it wishes to solicit, thereby presents administrative burden on both Commissioner and company.
7. Practicality.
- a. Does not represent essentially practical solution.
  - b. Question of whether Commissioner can proceed on own motion to institute criminal proceeding should be spelled out if method chosen.
- B. Compulsory Licensing.
- Solution presented in number of forms, basically consisting of requirement that every mail order insurer to be licensed in every state where it is doing business.
1. Requirement by Domiciliary State.
- a. Legal question seems settled in that state does have such authority under police powers. Enforcement problem appears simple.
  - b. Operational Effect. Would be efficient method and would have effect of making mandatory license for all insurers in every jurisdiction in which they transact business.
  - c. Selectivity. Method is not selective; treats legitimate and irresponsible alike. Factor involved in opposition to Hobbs bill which can be summarized as:
    - (1) Increase cost of insurance to public by
      - (a) Costs of licensing in various states;
      - (b) Capital and surplus requirements are often conflicting and stringent;
      - (c) Number of companies, especially those insuring particular types of persons or property such as ministers, teachers, church buildings, may not do sufficient business in state to justify expense of licensing. Faced with either writing at loss, discontinuing or increasing cost. Same objection applies to certain group plans for government workers and others.
    - (2) Would force companies to change methods of operation or form of organization. Countersignature requirements of some states would require non agency company to change to an agency system or operation.
  - d. Any scheme for local control which requires licensing would unfavorably affect responsible companies. Such proposals, in all fairness, should be accompanied by state action to revise and equalize capital and surplus requirements, modify unduly restrictive countersignature laws and permit legitimate forms of insurance organizations in all states.
  - e. Method does not provide for temporary relief pending adjudication.

state laws. Experience shows that adoption of uniform law is slow. Workability depends on uniform adoption by all states and territories.

2. Requirement by Other Than Domiciliary State.

a. Constitutionality; Jurisdiction. Basic issue is problem of gaining jurisdiction in state courts over absent nonresidents.

- (1) *Pennoyer vs. Neff*, 95 U.S. 714, held that if state legal proceedings in action in *personam* are to be valid, nonresident must either be served by process within state or make voluntary general appearance.
- (2) Court decisions since *Pennoyer* indicates recognition of use of equivalent service methods as meeting due process, for example, nonresident motorists statutes.
- (3) Could be applied to cover mail order insurers by consideration of concept of what constitutes "doing business."
- (4) Early case of *Minnesota Commercial Mens vs. Benn*, 261 U.S. 140, held unlicensed insurer not "doing business" since it had no offices or agents in state and business done only by mail.
- (5) *Benn* largely overcome by *Hoopeston Canning Co. vs. Cullen*, 318 U.S. 313, which indicates Court would approve "highly realistic" measures taken by states for protection of its citizens. Can be argued that *Hoopeston* will support conclusion that sending advertisements and contracts into state constitutes doing business to such extent as to make company subject to licensing, or
- (6) If Court would not so extend to justify result, argue that even under older cases companies are actually doing business because of numerous "contacts."
- (7) *Hoopeston* reinforced by *International Shoe Company vs. State of Washington*, 326 U.S. 310, which was brought to enforce judgment on tax claim under full faith and credit clause.
- (8) Question of whether state statute would be burden on interstate commerce as noted in SEUA. *Robertson vs. California*, 328 U.S. 440, Court held statute prohibiting residents as acting as agents for non-admitted insurer to be valid. Commerce clause, SEUA and P.L. 15, did not wipe out experience of state to regulate and clause is not a guaranty to import into a state whatever anyone pleases.

b. Enforcement.

(1) Full Faith and Credit Clause.

- (a) Even though state may have jurisdiction for purposes of suit against company ignoring licensing laws, would still not have defendant within its borders so as to enforce any judgment. Judgment must be taken to state of domicile and sued on there.
  - (b) States required to give full faith and credit to foreign decrees but is generally accepted that full faith and credit does not extend to decision under penal statute of sister state.
  - (c) Doctrine of *Huntington vs. Attrill*, 146 U.S. 657, appears to be relaxed under *Milwaukee County vs. White*, 296 U.S. 268, which was suit to enforce judgment for a tax claim. Court held judgment entitled to full faith and credit.
- (2) Might well be argued that violation of insurance licensing laws affects individual far more than failure to pay taxes and penalty decrees obtained under compulsory licensing statutes should be accorded full faith and credit.

c. Other Considerations.

- (1) If constitutional, would result in bringing foreign mail order in-

urers under state control to same extent as domestic companies. Commissioner would be able to police through presently existing administrative machinery.

- (2) Legislation should make sure that licensing requirements do not have onerous features as pointed out above in re Hobbs bill.
- (3) More meritorious than reciprocal action by state of domicile because does not depend on other state action.
- (4) Permits any single state to require licensing regardless of views or inertia of other states.

C. Service of Process Upon Unauthorized Insurers.

1. Unauthorized Insurers Service of Process Act approved by NAIC in 1948.
2. Method of substituted service of process upon unauthorized insurers.
3. Legality presumed.
4. Limitations recognized.
  - a. Does not meet problem of how to prevent insurers from continuing to issue policies by mail.
  - b. Hypertechnical construction of policies, unnecessary restrictions, exclusions and misleading advertising are not covered.

D. Use of Taxing Power.

1. Taxation of Companies.

- a. Legality. *Hoopston* and *International Shoe* doctrine has applicability. Latter case a tax case and has strong analogy to mail order issue.

- (1) "Contacts" which subject company to suit also subject it to tax. Collection of premium is one contact.
- (2) Taxation at different rate on unauthorized insurer could raise objections under Constitution Privileges and Immunities. Corporations are not citizens under this provision, therefore, state may levy higher tax on foreign corporations than domestics or no tax on domestics.
- (3) *Prudential vs. Benjamin*, 328 U.S. 408, held no burden on interstate commerce under P.L. 15 for state to tax foreign insurer without reference to character of transactions as interstate or local.
- (4) Assuming state can constitutionally tax proceeds of premiums collected within state by unlicensed insurers, question of enforcement under *Milwaukee County* appears to be that levy might be enforced under suit on tax judgment if found to have proper jurisdictional basis.

b. Operational Effect.

- (1) Act as deterrent, or serve as inducement to comply with licensing requirements in order to avoid punitive tax.
- (2) Neither answer is direct. Both require passage of time to assay effect of tax as compared with effects of licensing.
  - (a) Still possible, dependent on size of tax, that insurer would elect to do an unregulated business and to pay tax.
  - (b) Would afford revenue to state, but no protection to citizens.
  - (c) Not necessarily a prospective remedy; depends upon effectiveness.

c. Other Considerations.

- (1) Not selective.
- (2) Does not appear to be practical; indirect and conjectural in effect.

- (3) Raise cost of insurance sold by legitimate mail order insurers.
- (4) On other hand, would tend to equalize relative positions of licensed and unlicensed insurers.
- (5) Amounts to another form of compulsory licensing and as such, heir to all disadvantages noted above.

## 2. Taxation of Assureds.

### a. Legality.

- (1) View laid down in *Aligeyer vs. Louisiana*, 165 U.S. 578, held violation of due process.
- (2) Abandonment of this view noted in *Osborn vs. Ozlin*, 310 U.S. 53; *Hoopeston*.
- (3) Taxation of insured appears valid.
- (4) Legal enforcement and administrative problems would arise.

### b. Operational Effect.

- (1) Tax would have to be given widespread publicity.
- (2) To be effective, presence of tax must be known before person buys policy. No useful purpose served by notification of tax owing after acquiring policy.
- (3) Effect is extremely indirect.
- (4) Evil of illegitimate mail order business is fact insured may feel he is completely protected when such is not case. Tax on him merely serves to increase cost of inadequate coverage.

### c. Other considerations.

- (1) Method neither rapid nor certain and indirect.
- (2) Not selective.
- (3) Punishes individual insured.
- (4) Little or no effect upon operation of companies or on form of coverage.
- (5) No remedy to defrauded insured and no protection from being defrauded.

## E. Control of Advertising.

### 1. Prohibition of Advertising by Unauthorized Insurers.

- a. Legality. No state court cases on validity of current state statutes so prohibiting.
- b. Since aimed at media within state, no jurisdictional difficulty.
- c. Other considerations.
  - (1) Prospective in effect by insulating insurer from prospect in a few cases.
  - (2) Selective on extremely limited basis.
  - (3) Does not effect publication or origin outside state.
  - (4) If state of origin prohibits advertising by unlicensed insurers, media could not accept advertising from unlicensed insurer in that state even though insurer might be licensed in all states in which it does business.

### 2. Cooperative Control Over Advertising.

#### a. Legality.

- (1) No apparent constitutional problem.
- (2) Weight of authority indicates no cause of action against single newspaper which refuses to publish advertising.



- (3) Advertiser might, in absence of legislation, urge that concerted refusal by competitive newspapers to accept advertising amounts to boycott.
  - b. Other Considerations.
    - (1) Limited operational effect.
    - (2) Dependent upon voluntary cooperation which may vary.
- F. Service of Process Upon Unauthorized Insurers Engaged in Fraudulent Advertising. NAIC 1948 Model Bill.
- 1. Legality.
    - a. Act depends upon prior passage of Unfair Trade Practice Act by state.
      - (1) Commissioner to give notice to domiciliary state that insurer is using fraudulent advertising.
      - (2) If no action by domiciliary state within 30 days, Commissioner may proceed under Unfair Practice Act.
      - (3) Service of process similar to that under UIPA.
    - b. Legal problem arises as to enforcement of penalty for violation of cease and desist orders.
      - (1) Probably involve further suit in insurer's domiciliary state.
      - (2) Is money judgment obtained by state upon statutory penalty entitled to full faith and credit?
      - (3) *Huntington vs. Attrill*, supra, appears to have been broadened, therefore, possibility Supreme Court would hold such judgment entitled to full faith and credit and permit state control of advertising of unauthorized insurers.
  - 2. Other Considerations.
    - a. Gives Commissioner opportunity to institute remedial action on own motion since does not have to await complaint.
    - b. May issue cease and desist orders.
    - c. Although does not cover all aspects of problem, offers a means of coping with misleading advertising.
- G. Use By States of the Original Jurisdiction of the Supreme Court.
- Article III, Section 2, of U. S. Constitution provides for jurisdiction of U. S. Supreme Court in actions by state against citizens of another state. U. S. Code provides for original but not exclusive jurisdiction in such cases. Device proposed would be for state to use this jurisdiction to seek injunctions against unauthorized insurers using mails to defraud its citizens on grounds of nuisance.
- 1. Legality. Constitutionality.
    - a. Over what cases will U. S. Supreme Court assume jurisdiction.
      - (1) Not certain. Court has not so closely defined power of original jurisdiction as to make it impossible for state to seek remedy or redress against new peril. State "pecuniary" or "proprietary" interest not necessary.
      - (2) State interest must be that of quasi-sovereign.
    - b. Do operations of unauthorized insurers present such cases.
      - (1) If state has enforceable rights may utilize Supreme Court regardless of economic consequences to insurer.
      - (2) Nuisance concept may be related to illegitimate mail order insurers.
      - (3) Supreme Court could take jurisdiction if convinced injury to

state had occurred which could not be adequately remedied by private suits.

(4) Favorable decision in suit would be capable of direct enforcement against insurer. No full faith and credit problem.

(5) If action in nature of injunction, failure to comply would result in prosecution for contempt.

2. Other Considerations.

a. Injunction would be prospective and result in effectively preventing insurer from continuing illegitimate activities.

b. Operational effect of Supreme Court decision probably would extend beyond a restraint of one company.

c. Capable of selective operation.

d. Practical advantages.

(1) Does not require passage of uniform or similar laws by all states.

(2) Should not contain objectionable features of Hobbs bill.

(3) Promise of certainty in actual operation since injunction decree would run directly against insurer.

(4) Bring prestige of Supreme Court to bear on illegitimate operators and might bring about discontinuance of unfair practices without proceeding against such insurer.

(5) Has fair promise of being sustained; although Supreme Court might refuse to take jurisdiction due to practical considerations.

VIII. FEDERAL LEGISLATION IN AID OF STATE POWERS

A. The Postal Power.

1. Federal Law denying use of mails to insurers not licensed in state in which they attempt to do business.

a. Hobbs bill.

(1) Legislation in aid of state regulation. Ultimate constitutionality depends on power of state to regulate activity. If no state basis or power, such federal legislation would probably violate due process. If states have power, such federal legislation probably valid.

(2) Question of power of Federal Government to deny use of mails solely to assist states in enforcement of their laws. Probably valid.

b. Operational effect, speed, certainty, selectivity and practicality discussed above under Compulsory Licensing.

2. Federal law prohibiting advertising of insurance by mail in states where insurer is not licensed and which prohibit such advertising within the state by unlicensed insurers.

a. If states unable to control interstate advertising, federal statute could plug loophole.

b. Would force insurer to become licensed in all states if desired to advertise in magazine of national circulation. Exemption of such media would render act ineffectual to large degree.

B. The Commerce Power.

1. Federal statute prohibiting shipping insurance documents in interstate commerce where intended to be delivered, received or sold or possessed in violation of laws of state.

a. Precedent in Webb-Kenyon Act (liquor) and Ashurst-Summers Act (convict made goods) both upheld by Supreme Court as valid exercise in assisting states in enforcement of their laws.

b. Analogy of above Acts incomplete because:

- (1) Constant problem of whether mail order activities constitute "doing business." If not, may be violative of due process.
- (2) Insurance is an intangible and not susceptible to seizure by state as aid in enforcement.

c. Variation of compulsory licensing.

2. Federal statute prohibiting shipment in interstate commerce of advertising matter by mail order insurers into states which prohibit such advertising.
  - a. Akin to Postal Power proposal but shifts regulatory technique from mails to interstate commerce.
  - b. More closely analagous to Webb-Kenyon Act and bases regulation upon Federal Government powers over interstate commerce.
  - c. Requires licensing.
3. Federal Statute requiring mail order insurers to designate agent for service of process in each state where they solicit and failure to designate deemed appointment of state Secretary of State for such purpose.
  - a. Insurance is commerce under SEUA and Federal Government could use commerce powers to force designation of agent for service.
  - b. Same reasoning as in B. 1. b. above.
  - c. Little to gain from such legislation since if insurers are "doing business" state can gain jurisdiction without federal assistance.

C. The Judicial Power.

1. Federal statute designed to give district courts of U. S. concurrent original jurisdiction over suit brought by insured against unlicensed insurer in state of residence regardless of amount in controversy, to place venue of suit in district court within jurisdiction of residence and extend process power of court beyond limits of state in which such court is held.
  - a. Legality. Valid under Article III, Section I, U. S. Constitution and court decisions.
  - b. Venue, service of process and jurisdiction set forth in U. S. Code. Not practical.
  - c. Statutory exceptions in diversity cases set forth. Congress could, if given proper matter for concern, relax jurisdictional amount and diversity requirements.
  - d. Congress could change limitations on service of process by District Courts and there is precedent.
  - e. Other Considerations.
    - (1) Costs of action do not appear excessive.
    - (2) Possible to bring action in either federal or state courts and eliminate necessity of going to foreign state court, if insurer cannot be served, or, bring action under full faith and credit to enforce judgment.
    - (3) Eliminates jurisdictional barriers.
    - (4) Would not permit state to enjoin continuing operation of illegitimate insurer nor give anything but retrospective remedy.
2. Present original jurisdiction of district courts.
  - a. Federal question. Jurisdiction of all civil actions wherein controversy exceeds \$3000 and arises under Constitution, laws or treaties of U. S.

- (1) Depends upon plaintiff ability to show contention that federal question is real and substantial and of decisive bearing on action.
  - (2) Does not appear in instance under discussion that there is federal question. P.L. 15.
  - (3) FTC act does not appear to raise substantial federal question although FTC jurisdiction far from settled.
- b. Diversity of citizenship.
- (1) General rule that state is not "citizen" and suit between state and citizen or corporation of another state is not action between "citizens" of different states.
  - (2) Should be treated with caution since courts determine in each case whether state is actually party in interest.
- c. When state not the real party in interest.
- (1) If state has court decisions to effect that state is not a party to an action unless Attorney General brings suit in name of state, together with statutes authorizing Commissioner to bring injunction actions, there is fair chance district courts would assume jurisdiction.
  - (2) If no such decisions or as a supplement, could be argued in injunction action that state had no pecuniary interest and that real parties in interest were licensed insurers and public which purchases unauthorized insurance.
- d. Amount in controversy. (\$3000)
- (1) As general rule, damages or amount alleged in pleadings will be measure of jurisdiction unless colorable or extravagant.
  - (2) In nuisance injunction cases, amount may be found in loss to defendant if enjoined, value of right to be protected or extent of injury to be prevented.
- e. Venue. If action brought by state, would be brought in district court in which insurer resides, unless service could be had in plaintiff's district.
- f. Extension of Original Jurisdiction of District Courts.
- (1) Legal problems sufficient to warrant Congressional action.
  - (2) Supreme Court jurisdiction not exclusive under Article III.
- g. Suggested Congressional Legislation.
- (1) If drawn to bring mail order insurer, no matter how legitimate, within its scope, basically will be compulsory licensing.
  - (2) To avoid compulsory licensing, act must set its own standards and specify those activities which should be enjoined by district courts.
  - (3) Standards to be drawn so as to take into account varying opinions of several states.
  - (4) Mere operation as unauthorized insurer not sufficient factual basis upon which to maintain action involving nuisance theory.
  - (5) Possible standards would involve recapitulation of practices giving rise to complaints:
    - (a) Sharp claim practices.
    - (b) Misleading or fraudulent advertising.
    - (c) Benefits not commensurate with premium paid.
- h. Other Considerations.
- (1) Injunctive remedy ideal from regulatory and administrative

viewpoint. Prospective in operation and appears to be capable of fair degree of speed in operation.

- (2) Injunction would be certain in effect and enforceable against insurer at place of domicile without necessity of resort to full faith and credit.
- (3) Injunction is selective, in that Commissioner has discretion in selecting insurers against which actions should be brought.
- (4) Practical, since places administrative power to take action to protect residents in hands of Commissioner who is capable of making qualitative decisions.
- (5) Some are reluctant to seek Federal legislation in this area for fear of exposing weak point in state regulation. Weak point is well known and former should not block. Industry has sought assistance of Congress in other areas.

#### IX. STATE COOPERATION WITH THE POST OFFICE DEPARTMENT

##### A. Fraud Orders.

1. Powers of Postmaster General to issue fraud orders set forth as well as court decisions interpreting powers.
2. On basis of statutes and court decisions, fraud orders appear to be legal vehicle well adapted to dealing with mail order.
  - a. Deceptive or misleading policy provisions and advertising.
  - b. Failure to pay valid claims.
3. No reported cases of fraud orders being issued against insurers.
4. Effect of order would be to put insurer out of business.

##### B. Operational Effect.

1. Procedures set forth as to issuance of fraud orders.
2. Judicial review of orders.

##### C. Speed and Certainty.

1. Capable of effective use.
2. Procedures not cumbersome.
3. Selective in operation, particularly with cooperative efforts with state Commissioner.

##### D. Other Considerations.

1. Practical.
2. Complete cutoff of use of mails by insurer.
3. Would necessitate state cooperation in prosecution in order to alleviate burden on Post Office Department.

#### X. FEDERAL GOVERNMENT CONTROL UNDER THE FEDERAL TRADE COMMISSION ACT

##### A. FTC Jurisdiction.

1. Misrepresentation or false advertising of nature of contract falls within FTC Act.
2. P.L. 15 presents question as to applicability of insurance.

##### B. State Fair Trade Practices Act.

C. Judicial determination necessary as to extent, if any, of FTC jurisdiction.

D. Development of FTC trade practice rules.

E. Enforcement of rules.

F. Other Considerations.

1. Cease and desist orders capable of prospective, quick and certain operation.
2. Capable of reasonable certainty.
3. Could be selective.
4. FTC activity depends on governmental philosophy.
5. Advertising jurisdiction of FTC would not completely solve sharp claim practice problems. Would not provide for approval of policy forms.
6. Raises many questions of dual regulation.

**XI. APPENDICES**

- A. 1912 Uniform Standard Provision Bill.
- B. 1949 Accident and Sickness Policy Provisions Law.
- C. Guide for Filing of Forms (The NAIC Official Guide).
- D. Proposed Amendment to Law for Personal Accident and Health Insurance.
- E. Statement of Principles Personal Accident and Health Insurance.
- F. Index to NAIC Proceedings, 1871-1948.
- G. Uniform Unauthorized Insurers Act.
- H. Statutory Licensing and Other Annual Fees for Accident and Health Companies; Deposit and Bond Requirements.
- I. Capital and Surplus Requirements for Selected States.
- J. States Requiring That Policies Be Placed Through Resident Agents Or Be Locally Countersigned.
- K. State Requirements That Local Commissioners Be Paid on Business Originating Outside the State.
- L. Unauthorized Insurers Process Act.
- M. Laws of Maryland, Massachusetts and Ohio in re advertising by Unauthorized Insurers.
- N. Unauthorized Insurers False Advertising Process Act.
- O. New York Insurance Law, Article IX-D (Fair Trade Practices Act).
- P. Act (proposed) to Prohibit the Use of the Mails or any Facility of Interstate Commerce for the Furtherance of the Issuance or Sale of Non-Permitted Insurance.
- Q. Act (proposed) Divesting Insurance Documents of Their Interstate Character in Certain Cases.
- R. Proposed (FTC) Trade Practice Rules for the Mail Order Insurance Industry (Draft rules for hearing May 25, 1949).

## PART II

STUDIES AND ACTIONS OF  
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS  
IN REGARD TO MAIL ORDER INSURERS

JUNE 1, 1949

Regulation of Mail Order Accident and Health Insurance by George H. Kline, New York Insurance Department, *Proceedings*, NAIC 1949, page 499. (See attached outline of Kline Report). Covers NAIC activities from 1895 through early 1949.

JUNE 23, 1949

NAIC Special Committee to Act as Liaison Committee with Federal Trade Commission. Included report on hearings held by FTC on proposed trade practice rules for mail order industry. Question raised as to whether FTC proposed rules were to be applicable to all insurers doing business outside state of domicile. FTC had not decided extent of jurisdiction or assertion of jurisdiction over "quality" of state regulation. No concession made by NAIC of FTC regulatory authority nor power to judge quality and it maintained that states have exclusive regulatory power when regulated by state law. *Proceedings*, 1949, page 395.

DECEMBER 6, 1949

Unauthorized Insurers Committee. All Industry Subcommittee reports that consideration of a limited licensing bill was terminated at suggestion of proponents. Consideration being given to many matters noted in Kline Report but no definite conclusions reached. *Proceedings*, 1950, page 109.

JUNE 14, 1950

Unauthorized Insurers Committee. All Industry Subcommittee suggested an exploration of subject of mail order insurers in light of Supreme Court decision in *Travelers Health vs. Virginia*, 339 U.S. 643, *Proceedings*, 1950, pages 547-548.

DECEMBER 15, 1950

Unauthorized Insurers Committee. Received report from All Industry Subcommittee: (1) Unauthorized Insurers Service of Process Act enacted in 18 states and that most constitutional questions resolved favorably in *Travelers Health vs. Virginia*; (2) A draft bill on False Advertising Service of Process was still under consideration and copy of draft attached to report.

A brief prepared by Mr. Henry Moser, on behalf of NAII was also submitted. Brief discussed questions: (1) Is a money judgment obtained by a state on a statutory penalty for unfair trade practices against a foreign unauthorized insurer entitled to full faith and credit in a sister state where the insurer is domiciled? *Conclusion*: Since policy considerations supporting enforcement appear to outweigh considerations supporting the penal law exception laid down in *Huntington vs. Atrill* and modified by *Faulteroy vs. Lum*, the likelihood is that the judgment will be given full faith and credit. (2) Enforceability of injunctions under Full Faith and Credit Clause. *Conclusion*: An injunction against an insurer forbidding false advertising activities establishes the right of the state as against the insurer and a court of equity in the state of insurer's domicile has adequate power and procedures to enforce a decree of its own ordering cessation of activities. A lack of guiding precedent in this field makes hazardous the enunciation of very positive opinions on what the U. S. Supreme Court might do. On the other hand, absence of contrary authority against full faith and credit, the persuasive policy arguments in favor of enforcement and a general tendency of Court to expand areas of full faith and credit do indicate chances of a favorable holding are good. *Proceedings*, 1951, pages 165-179.

DECEMBER 3, 1951

Unauthorized Insurers Committee eliminated mail order insurance from its agenda until such time as future developments may require further action. *Proceedings*, 1952, pages 37-38.

DECEMBER 1, 1953

Unauthorized Insurers Committee. Report indicates that an invitation had been received from U. S. Senate Judiciary Committee for NAIC to appear before it in regard to Com-

mittee inquiries into practices in connection with the sale of A & H and life insurance through the mails. Inquiry was to deal with: (1) Repeated complaints and difficulties encountered in sale of insurance by mail; (2) Statutory remedies by (a) federal legislation; (b) state legislation; (3) Practices and policies of some state insurance departments; (4) Other comments.

NAIC Committee adopted a resolution recommending a special committee be appointed to canvas and ascertain views of all commissioners on the contents and implications of the Senate Committee inquiry and to appear before the Committee. *Proceedings*, 1954 Volume I, pages 151-160.

#### JUNE 8, 1954

Unauthorized Insurers Committee. The Special Committee on Mail Order Insurers in connection with Senate Judiciary Committee appeared before the Senate Committee on February 26, 1954. The statement presented by Commissioner Allyn of Connecticut referred to: (1) Continual NAIC studies of the problem and the progress made; (2) Warnings issued by commissioners about unauthorized insurers; (3) Adoption of UISPA in 40 states; (4) Cooperation of FTC, Post Office and Justice Departments; (5) Studies being made currently by FTC; (6) Mail order A & H constitutes only about 3% of total premium volume; (7) Many mail order companies operate on a sound basis but some companies use misleading advertising; (8) Most mail order advertising directed at older persons; (9) Large increase in A & H business and resulting complaints has led to NAIC 1950 Uniform Policy Provisions Law, and current studies of problems of pre-existing conditions, cancellations and loss ratios; (10) Rejected idea of standard policies which would be a bar to necessary flexibility in the business; (11) Adequacy of coverage can only be judged by needs of the person buying coverage and the amount of money he wishes to spend; (12) Not fair to condemn the whole business for actions of a few companies; (13) Hobbs bill opposed originally by NAIC because of fear of federal regulation. Such bill not really necessary now and regulation best left to states; (14) NAIC unalterably opposed to federal regulation. *Proceedings*, 1954, Volume II, pages 343-361.

#### JUNE 9, 1954

Accident and Health Committee. Consideration and adoption of 3 resolutions: (1) Recommended enactment of adequate and comprehensive legislation including sufficient and appropriate authority for the regulatory official to cope with unfair and misleading advertising; (2) Enactment of State Fair Trade Practices Act and Reciprocal Unauthorized Insurers Act; (3) Enactment of Uniform Policy Provisions Law containing the "Time Limit on Certain Defenses" provision.

Committee discussions also referred to the U. S. Senate Judiciary Committee inquiry and FTC studies. *Proceedings*, 1954, Volume II, pages 249-254.

#### OCTOBER 4, 1954

Special meeting of Accident and Health Committee to conduct a survey of A & H complaints. Details of form of survey reviewed by Committee and Joint Committee on Health Insurance Task Force 2. *Proceedings*, 1955, Volume I, pages 86-92.

#### NOVEMBER 29, 1954

Executive Committee. Authorized appointment of Special Committee to Explore Jurisdiction of FTC. To report to Liaison Committee. *Proceedings*, 1955, Volume I, pages 41-42.

Special Meeting of Accident and Health Committee to review results of the nationwide complaint survey and consider recommendations. *Proceedings*, 1955, Volume I, page 75.

#### DECEMBER 1, 1954

Joint meeting of Accident and Health and Liaison Committees. Recommendations made as result of complaint survey.

##### 1. Legislation requiring:

- (a) Cancellable or optionally renewable policies and advertising to contain prominent statement to that effect and where details of benefits are set forth in any advertisement, disclosure of major limitations to be made;
- (b) Individual cancellable or nonrenewable policies contain prominent statement to that effect on first page;
- (c) Individual policies to contain a provision fixing a period during which policyholder shall read policy and have right to surrender it.



2. Adequate Fair Trade Practices Acts as recommended by NAIC.
3. Reciprocal Unauthorized Insurers Act (New York voted no on this recommendation).
4. Adoption of Uniform Policy Provisions Law.

*Proceedings*, 1955, Volume I, pages 75-83.

MAY 31, 1955

Joint Meeting of Federal Liaison Committee and Special Committee to Study Question of Jurisdiction of FTC. Announcement of FTC proceedings against A & H insurers advertising. Conclusions reached as result of Committee studies of FTC jurisdiction:

1. Regulation by states of false advertising or unfair trade practices whether exercised by cease and desist order or licensing power or other means preserves jurisdiction of states and excludes FTC jurisdiction.
2. In order to retain state jurisdiction, laws may be passed at any time not necessarily prior to June 30, 1948, the date the moratorium under P.L. 15 expires.
3. State regulatory statutes must have provision for administrative enforcement in order to exclude FTC jurisdiction.
4. State statutes which fail to substantially cover an area covered by FTC Act do not preserve jurisdiction to state in that area.
5. Whether state statutes in fact regulate advertising and unfair practices is determined by appraisal of state law. Statutes do not need to re-enact or parallel federal law; may have divergent patterns.
6. P.L. 15, Section 2, b., does not mean concurrent FTC and state jurisdiction when state law covers the area.
7. P.L. 15, Section 2, b., does not give FTC power to judge quality of state regulation under state law.
8. States have power to regulate the business of domestic insurers even though the regulation may extend beyond the state of domicile.

Committee recommended that in order to preserve state regulation, states adopt the State Fair Trade Practices Act, Unauthorized Insurers Service of Process Act, Unauthorized Insurers False Advertising Service of Process Act and the Reciprocal Licensing Act. Also that NAIC and industry develop rules and regulations or guides on misleading and deceptive advertising. Advertising Code Subcommittee appointed. *Proceedings*, 1955, Volume II, pages 327-337.

NOVEMBER 29, 1955

Federal Liaison Committee. Adopted report of Advertising Code Subcommittee which contained: (1) Advertising Rules; (2) Recommendation that permanent committee on interpretation of Rules be appointed to develop an Interpretive Guide. *Proceedings*, 1956, Volume I, pages 127-137; 144-147.

NOVEMBER 30, 1955

Accident and Health Committee. Subcommittee on Interpretation of Advertising Rules appointed. *Proceedings*, 1956, Volume I, page 88.

JUNE 1, 1956

Executive Plenary Session. Resolution containing following points adopted:

1. NAIC disagrees with and deplores the majority opinion of FTC in the *American Hospital and Life Company* case which is contrary to the intent of Congress in P.L. 15 and an unwarranted assumption of power to regulate insurance.
2. A Committee on Preservation of State Regulation be appointed, to report to Executive Committee, and authorized to take steps in urging action on part of states in order to make certain that issues raised by FTC decision or other similar decisions receive full and complete review by the Courts.
3. State Attorneys General be acquainted with issues and urged to take all necessary steps to preserve state regulation.

*Proceedings*, 1956, Volume II, pages 432-433.

## DECEMBER 3, 1956

Preservation of State Regulation Committee. Discussed status of cases pending in U. S. Circuit Courts involving FTC jurisdiction over insurance advertising. Chairman was requested to prepare and send questionnaire to all states to obtain citations of all state statutes which regulate false advertising of insurance. *Proceedings*, 1957, Volume I, pages 71-73.

## JUNE 12, 1957

Joint Meeting of Preservation of State Regulation and Federal Liaison Committees. Received report that cases of *Crafts vs. FTC*, *American Hospital and Life Company vs. FTC* and *National Casualty Company vs. FTC* had all been decided by U. S. Circuit Courts in favor of insurers and against FTC. It was noted that many briefs amicus had been filed by trade associations, commissioners and state attorneys general. *Proceedings*, 1957, Volume II, pages 301-308.

Laws and Legislation Committee. Appoints Subcommittee to Study and Review State Laws Necessary to Perfect State Regulation. *Proceedings*, 1957, Volume II, page 382.

## DECEMBER 3, 1957

Joint meeting of Preservation of State Regulation and Federal Liaison Committees. Report included following:

1. NAIC-FTC conference on various problems of mutual interest in matter of regulation of advertising practices of A & H insurance companies. Resulted in agreement that FTC will establish a procedure under which information and inquiries received by it will be made available to appropriate state insurance regulatory official.
2. Litigation involving *American Hospital and Life Company* and *National Casualty Company vs. FTC*. U. S. Supreme Court agreed to review appeal by FTC from Circuit Court decisions upholding companies views. Noted *Travelers Health vs. FTC* litigation pending in Eighth Circuit Court and *McGee vs. International Life Insurance Co.* involving UISPA in California.

*Proceedings*, 1958, Volume I, pages 67-75.

## DECEMBER 16, 1958

Federal Liaison Committee. Reported U. S. Supreme Court upheld company positions in *American Hospital and Life* and *National Casualty* cases, that FTC has no jurisdiction over their operations. FTC had, therefore, dismissed complaints against 16 other companies with similar factual situations in addition to the case of *Crafts vs. FTC*. Noted that *Travelers Health vs. FTC* case was still pending and will be reargued in light of Court ruling.

Laws and Legislation Committee. Subcommittee to Study and Review State Insurance Laws received a report prepared by New York Department staff (the so-called Shantz Report) which included sections dealing with unauthorized insurers. This report contained the following items of interest:

1. A review of the Kline Report of 1949.
2. Notation that the constitutionality of the UISPA had been upheld by the U. S. Supreme Court in *McGee vs. International Life*.
3. Question of enforcement of injunctions in another state still open to question.
4. Legislation recommended: Fair Trade Practices Act including section on undefined practices; UISPA; Uniform Policy Provisions Law; NAIC Advertising Rules; require domestic insurers to be licensed in states in which they solicit business either by mail or otherwise; Amendment to Fair Trade Practices Act to provide for control of out of state practices of domestic companies.
5. Further study of desirability of model legislation in following areas:
  - (a) Legislation affording commissioner same privilege of invoking his state court's jurisdiction over unauthorized insurers as is presently given assured's and beneficiaries under UISPA.
  - (b) Enforcement on a reciprocal basis of penalty judgments and injunction orders.

(c) A definition of "doing business" which will be broad enough, and meet constitutional standards, to compel presently exempt unauthorized insurers to secure a certificate of authority if they wish to solicit business in a state even if only by mail.

(d) As an alternative to c., approval by NAIC of the UIFASPA.

Subcommittee directed further study of report and authorized appointment of Industry Advisory Committee. *Proceedings*, 1959, Volume I, pages 131-132; 135-178.

#### DECEMBER 17, 1958

Accident and Health Committee. Subcommittee on Regulation of Advertising had held two meetings relative to the Nebraska and Connecticut amendments to the State Fair Trade Practices Act which specifically provided for regulation of domestic company trade practices done outside state of domicile. HIAA recommended NAIC adopt this approach. It was pointed out that the Nebraska amendment was before the Circuit Court and had been reargued in *Travelers Health vs. FTC*. The Subcommittee took no action on the HIAA recommendation pending the Circuit Court decision. *Proceedings*, 1959, Volume I, pages 90-93.

#### JUNE 8, 1959

Subcommittee to Study and Review State Insurance Laws. Report of Subcommittee meeting of April 1, 1959, which reviewed the recommendations contained in the December 1958 report and decision to prepare drafts of recommended legislation. Industry comments included a caution in regard to insisting that the State Fair Trade Practices Act contain Section 9, the undefined practices section, since such section may be unnecessary and creates tendency towards a challenge that Act is inadequate without section; objections to the compulsory licensing proposals; objections based upon possibility of legislation hampering formation of reinsurance pools. The Subcommittee voted to undertake further exploration of the issues raised and the proposed model legislation. *Proceedings*, 1959, Volume II, pages 514-517.

Joint meeting of Preservation of State Regulation and Federal Liaison Committees. Reported that Eighth Circuit Court had held in favor of company in *Travelers Health vs. FTC* citing Nebraska amendment to State Fair Trade Practices Act. Certiorari granted by U. S. Supreme Court. Five FTC complaints still in effect against direct mail insurers. *Proceedings*, 1959, Volume II, pages 459-463.

#### NOVEMBER 30, 1959

Subcommittee to Study and Review State Insurance Laws. Subcommittee had met on November 5 and considered a bill defining "doing business" and a bill to permit service on unauthorized insurers in proceedings instituted by a state regulatory agency. The Industry Advisory Committee reported that it was not yet ready to submit a formal report and urged a delay in consideration of the proposed legislation until the Supreme Court rules in the *Travelers Health* case. Subcommittee accepted Industry Advisory Committee recommendation. *Proceedings*, 1960, Volume I, pages 188-189.

#### JUNE 30, 1960

Subcommittee to Study and Review State Insurance Laws. Subcommittee received report from the Industry Advisory Committee which recommended:

1. NAIC adoption of the Unauthorized Insurers False Advertising Service of Process Act in the form attached to the report.
2. NAIC urge the enactment of the UIFASPA in all states and territories.
3. NAIC make no recommendation for amendments to the various state statutory definitions of "doing business" as a means of attempting to solve problems of regulating direct mail advertising.

The Committee report related the advantages of UIFASPA as enabling the commissioner to take action on his own motion to control such advertising; satisfies the standards of P.L. 15 as foreclosing FTC jurisdiction as noted in the legislative history of P.L. 15; satisfies the standards offered by the U. S. Supreme Court in the *Travelers Health* case where it was stated: "In our opinion the state regulation which Congress provided should operate to displace this federal law means regulation by the State in which the deception is practiced and has its impact."

The disadvantages of broadening the statutory definition of "doing an insurance business" were noted as including:

1. Would fail to accomplish its objective and be ineffective. In the *McGee* case, the Court referred to the continuing process of evolution under which "consent,"

“doing business” and “presence” had been accepted and then abandoned as standards for measuring state judicial power over foreign corporations.

2. Would have undesirable consequences with reference to tax questions since the Court has admitted that its decisions are not clear and further that the “doing business” concept based on tax decisions are far from settled. Contacts within a state justifying application of a tax are not necessarily sufficient to justify regulation. Extraterritoriality is implicit in this approach and would result in overlapping jurisdictional conflicts. The result is compulsory licensing which would force good companies out of business as well as bad.
3. Premium volume written by direct mail insurers is probably less than 1% of the total health insurance premium volume.
4. Other questions raised as result of approach would be its effect on group insurance, “orphan” business, reinsurance and self insurance.

The Committee report also contained a rationale as to the legality and enforcement of violation of cease and desist orders under UIFASPA.

The NAIC Subcommittee indicated its agreement with the stated objectives of UIFASPA but felt, however, aside from some editing, the act did not allay all concerns which are not limited to false advertising but all unlawful activities of such insurers. Efforts should be continued toward reaching more comprehensive solutions. A suggestion was also made as to the possibility of interstate compacts as meeting the problem. *Proceedings*, 1960, Volume II, pages 485-516.

#### NOVEMBER 28, 1960

Subcommittee to Study and Review State Insurance Laws, Second Industry Advisory Committee report submitted which responded to questions raised at the June 1960 meeting. The questions and Committee answers were:

1. Should UIFASPA be extended to include, in addition to false advertising, other unfair trade practices enumerated and prohibited under the State Fair Trade Practices Act? *Answer*: No, since the majority of complaints relate to advertising.
2. Should UIFASPA provide for such equitable relief as well as damages at law for violations? *Answer*: No. While it was demonstrated in the previous report that judgments under UIFASPA providing for payment of money would be entitled to full faith and credit, it is questionable whether the same would be true with respect to injunctions.
3. Would interstate compacts be an appropriate and effective means of strengthening state regulation of direct mail advertising? *Answer*: No. Previous NAIC and All Industry Committee considerations resulted in negative answer on grounds that such compacts would likely take away regulation by states and transfer it to some other regulatory body (See *Proceedings*, 1951, pages 161-162). It is also likely that compacts of this nature would need Congressional approval.

The NAIC Subcommittee discussed the foregoing report and 2 draft bills relating to prohibition of domestic company solicitation outside state of domicile unless licensed and the establishment of procedures authorizing commissioner to proceed against an unauthorized insurer for violation of laws and regulations in his state. The Subcommittee concluded that at the present time, only the UIFASPA be adopted. *Proceedings*, 1961, Volume I, pages 309-316.

#### JUNE 19, 1962

Federal Liaison Committee. Committee discussed the decision of the Eighth Circuit Court in the *Travelers Health* case upholding the jurisdiction of FTC over the company's advertising. Reference made to the NAIC-FTC agreement of November 29, 1957 (*Proceedings*, 1958, Volume I, page 67). Expressed opinion that Court decision should not change the reasons and objectives of the 1957 and commissioners should renew liaison with FTC in accordance with the agreement. *Proceedings*, 1962, Volume II, pages 406-407.

#### JUNE 20, 1962

Accident and Health Committee. Regulation of Advertising Subcommittee reviewed the Eighth Circuit Court decision in the *Travelers Health* case and heard a report in regard to the FTC announcement of its repeal of its 1950 Rules on A & H advertising and anticipated new regulations. Requested that Executive Committee designate a

Committee or Subcommittee to confer with FTC. *Proceedings*, 1962, Volume II, pages 366-367.

DECEMBER 4, 1962

Unauthorized Insurers Committee. Recommended that any state desiring to consider the NAIC Non Admitted Insurers Act draft should evaluate the draft in light of the U. S. Supreme Court decision in the case of *Todd Shipyards vs. State Board of Insurance*, 370, U. S. 451. *Proceedings*, 1963, Volume I, pages 247-248.

DECEMBER 5, 1962

Accident and Health Committee. Subcommittee on Regulation of Advertising reported that the Federal Liaison Committee had been designated to effectuate liaison with FTC on its new proposed advertising rules. A recommendation was made that a new Subcommittee be created to fully study all insurance company advertising, not just A & H, and that it cooperate with the Federal Liaison Committee in FTC relations. *Proceedings*, 1963, Volume I, page 81.

JUNE 19, 1963

Advertising of Insurance Committee. Committee discussed an outline of its proposed tasks which included:

1. Comments on the FTC staff drafts of its proposed "Guides" for mail order advertising.
2. Development of a model advertising bill patterned after Louisiana Insurance Code, Section 1523.
3. Revision and expansion of NAIC Advertising Rules to cover all insurance advertising.
4. Surveillance of the 1957 NAIC-FTC agreement.

*Proceedings*, 1963, Volume II, page 723.

Federal Liaison Committee. Report submitted on meeting of Committee with FTC. FTC has proposed and put into effect the following procedure with respect to complaints it receives:

1. Where it appears FTC has no jurisdiction, FTC will refer complaint to commissioner of insurer's state of domicile with copies to commissioner of state where complainant resides and NAIC Executive Secretary.
2. Where it appears that FTC has jurisdiction, it will initiate such action as the facts warrant and inform commissioner of insurer's state of domicile of action taken.

The Committee recommended that NAIC adopt a resolution which recommends that each commissioner institute the following procedure in regard to complaints involving unfair or deceptive advertising by mail order insurers:

1. Where complaint is received in a jurisdiction where company is not licensed, commissioner will promptly refer complaint to commissioner of state of company's domicile.
2. If commissioner in state of company's domicile fails to act upon complaint within a reasonable time, the original commissioner will refer the complaint to FTC.

The NAIC subsequently adopted the Committee's recommended resolution.

Committee also received a report from Insurance Department staff representatives on meeting with FTC on its proposed "Guides" for mail order advertising. *Proceedings*, 1963, Volume II, page 539.

DECEMBER 3, 1963

Advertising of Insurance Committee. Committee report contains a copy of a press release relating to the NAIC-FTC agreement of June 1963. Agreement also referred to in Federal Liaison Committee report. *Proceedings*, 1964, Volume I, pages 125 and 243.

DECEMBER 1, 1964

Advertising of Insurance Committee. Report contains reference to NAIC Executive Secretary report in regard to surveillance of the NAIC-FTC arrangement in which it

was indicated there was a lack of effective communication of responsibilities undertaken by individual commissioners. Executive Secretary is to contact commissioners to be certain that joint arrangement is carried out as contemplated. *Proceedings, 1965* Volume I, pages 219-220.

JUNE 10, 1965

Advertising of Insurance Committee. Committee had met on May 4 to consider a response to inquiry received from U. S. Senator Harrison Williams, Chairman of Senate Subcommittee on Frauds and Misrepresentation Affecting the Elderly in regard to mail order insurers.

The Committee introduced 2 Resolutions and asked for industry comments in regard thereto at the December meeting. Proposed Resolutions were:

1. That the NAIC-FTC Resolution be studied as to its effectiveness and amendments recommended to strengthen the position of NAIC and its members by collective action and coordination through the NAIC Executive Secretary's office.
2. Advertising Concord Subcommittee be appointed to undertake a study of mail order solicitation and other forms of solicitation by unlicensed insurers and recommend measures to effect a concord among the NAIC membership.

*Proceedings, 1965, Volume II, pages 645-649.*

OCTOBER 12, 1965

Advertising of Insurance Committee. Report submitted upon the status of correspondence with Senate Subcommittee on Frauds and Misrepresentations Affecting the Elderly and copies of correspondence were attached to the report. Also considered resolutions introduced at June 10 meeting and authorized appointment of Subcommittee to Study NAIC-FTC Resolution and Subcommittee to Study a NAIC Advertising Concord. *Proceedings, 1966, Volume I, pages 217-221.*

NOVEMBER 30, 1965

Advertising of Insurance Committee. Report of Subcommittee to Study NAIC-FTC Resolution received which indicated discussion of the possibility of devising a questionnaire to be forwarded to commissioners in order to elicit information which might be helpful in making the 1963 resolution more effective. The Subcommittee to Study a NAIC Advertising Concord received a recommendation from ALC-HIAA-LIAA that additional advertising studies by the Subcommittee be deferred until the results of earlier NAIC studies and recommendations have been given a fair opportunity to solve the problems. Further views were requested for consideration at the next meeting.

The Advertising of Insurance Committee discussed the purposes of the 2 Subcommittees indicating that under the 1963 NAIC-FTC Resolution NAIC was not really involved since it only provides a procedure involving the complaining state and state of domicile of insurer before referral to FTC Purpose of Subcommittee to determine how full NAIC can be made a part of the procedure.

It was also noted that the NAIC Advertising Rules and UIFASPA are also available to assist the states in regulating unlicensed insurer advertising; however, none of these vehicles strike at the heart of the unlicensed mail order insurer problem, which is the responsibility of each state to enforce its laws and for collection of its just taxes.

*Proceedings, 1966, Volume I, pages 215-216; 221-223.*

JUNE 22, 1966

Advertising of Insurance Committee. The Subcommittee to Study NAIC-FTC Resolution reported on the results of the survey of the various commissioners as to the effectiveness of the Resolution. Conclusions reached as a result of the survey included:

1. Complaints regarding unfair or deceptive advertising by unlicensed mail order insurers are widespread.
2. Complaints are directed at only a few companies; primarily life and A & H companies.
3. The NAIC-FTC Resolution is only partially effective.
4. Fifty percent of the states indicate consideration being given to introduction of legislation similar to the Wisconsin Unauthorized Insurers law and 23 states favor enactment of either a model act or legislation similar to the Wisconsin

law or the California statute. (A copy of the survey results are attached to the Subcommittee report.)

The Subcommittee discussed possibilities of recommending model legislation or amending the NAIC-FTC Resolution but decided to recommend that a resolution be adopted by NAIC which would provide, in substance, that no insurance company, other than one operating under the surplus lines laws, shall solicit or write, directly or indirectly, any insurance in any state in which it is not so authorized and Subcommittee or other appropriate Committee be instructed to go forward to implement this resolution.

At the meeting of the parent Committee, industry representatives opposed the adoption of the resolution; continued its support of the statement made at the December 1965 meeting; and, pointed out the practical considerations and problems raised by the proposed resolution. In executive session, the Committee adopted the Subcommittee report stating that it believed a position of NAIC should be stated at this time.

At the Plenary Session, the Advertising of Insurance Committee report was referred back to the Committee for further study and was, therefore, not adopted by NAIC.

*Proceedings*, 1966, Volume II, pages 605-611.

DECEMBER 7, 1966

Advertising of Insurance Committee. The Subcommittee to Study NAIC-FTC Resolution recommended the adoption of a two point resolution which provided in substance:

1. That the states take such steps as may be necessary and appropriate to prohibit the use of the U. S. Mails (or other devices) to evade or avoid otherwise applicable state laws pertaining to regulation of insurance;
2. This Subcommittee or another appropriate Committee be instructed to study and draft recommendations, including legislation, dealing with activities of unauthorized insurers and report at the June 1967 meeting.

At the meeting of the Committee, the Subcommittee resolution was adopted with the change noted above in parenthesis. (It was also reported at this meeting that the U. S. Supreme Court had dismissed the appeal of the Wisconsin Supreme Court decision in the case of *Ministers Life and Casualty vs. Haase* on grounds of "a lack of a substantial federal question.") The Committee report was adopted at the Plenary Session. *Proceedings*, 1967, Volume I, pages 215-219.

JUNE 14, 1967

Laws and Legislation Committee. The Chairman of the Committee noted that item on agenda had been referred to this Committee by the President of NAIC and is an outgrowth of a resolution submitted by the Advertising of Insurance Committee at the December 1966 meeting. Several new developments were reported including the enactment of new legislation in some states and the upholding of the California Insurance Department attempt to enjoin operations of unauthorized insurers by the California Supreme Court. It was recommended in light of these developments, that a Subcommittee be appointed to draft recommendations and legislation, if necessary, dealing with unauthorized insurers and that an Industry Advisory Committee be appointed to consult with and assist the Subcommittee in its research. The recommendation was adopted. *Proceedings*, 1967, Volume II, pages 365-366.

To Make Recommendations, including drafting of Model Legislation  
if necessary, dealing with Unauthorized Insurers (D4) Subcom. Report  
(Mtg. #21)

The Laws and Legislation Subcommittee To Make Recommendations, including drafting of Model Legislation, dealing with Unauthorized Insurers met December 4, 1967 in the Kauai Room, Honolulu, Hawaii. (ref: 1968 Proc. Vol. I p. 121). The subject of proper exemptions to a model statute received considerable discussion. Chairman Faulstich indicated serious consideration would be given to the particular problems of charitable, religious and educational institutions. Quorum being present, matters on the agenda were considered and the following action taken:

1. The Subcommittee recommends the establishment of an Industry Advisory Committee to do necessary research relating to the regulation of unauthorized insurers.
2. The Subcommittee recommends the preparation of model legislation in this area to be presented for final action by the National Association of Insurance Commissioners at their December 1968 meeting.

Hon. James R. Faulstich, Chm., Ore.; Hon. Frank M. Hogerty, Jr., Maine; Hon. Thomas C. Hunt, Minn.; Hon. Donald Knowlton, N. H.; Hon. Edwin S. Lanier, N. C.; Hon. David O. Maxwell, Pa.; Hon. Durwood Manford, Texas; Hon. Robert D. Haase, Wis.



APPENDIX TWO:  
MINORITY VIEWS OF THE NATIONAL ASSOCIATION  
OF LIFE UNDERWRITERS

Parts I and II of the majority report of the Industry Advisory Committee on Unauthorized Insurers set forth the history of the issue and the mission of the Industry Committee. Parts III and V enunciate certain fundamental principles which should be considered in connection with any proposed model legislation on the subject of unauthorized insurance, and discuss procedures for the enforcement of such statutes. We generally endorse these portions of the report. The Industry Committee, under the talented leadership of Chairman Edwards, is to be congratulated for the careful attention devoted to these subjects.

However, as to Part IV of the report, entitled "Areas of Non-Applicability," we find ourselves unable and unwilling to endorse the majority opinion, and therefore we submit these dissenting views.

The object of Part IV is to secure special exemptions and exceptions for numerous interests within the insurance industry. To itemize, there is an exemption for group insurance, for so-called "orphan" business, for surplus lines business, and for insurers transacting business with colleges and universities; there is an exemption for reinsurance, for ocean marine insurance, and for insurers issuing coverage to corporations doing a multi-state business. Any model bill drafted pursuant to Part IV of this report would surely be a "Christmas Tree" bill. We do not believe that the NAIC, in its increasingly important role as advisor to the states, should promulgate a model bill which endorses the something-for-everyone approach to regulation which is suggested by Part IV of the Industry Advisory Committee's report. We are quite concerned that the granting of exceptions might go a long way toward defeating the very purpose of the model legislation under consideration. To take just one example, in seeking to justify an exemption for group insurance, the majority of the Committee suggests that "The proposed model bill might limit the group exemption to situations in which the master policy is validly issued in and pursuant to the laws of a state in which the insurer is authorized to do an insurance business and in which the policyholder is domiciled or otherwise has a bona fide situs."

We submit that this might not only fail as a safeguard, but that it might in fact chart a clear channel for those who are determined to do an unauthorized insurance business throughout the United States.

A direct mail insurer could abandon its solicitation of individual policies and adopt a group method of operation. The insurer could issue a master contract to a trust having a bona fide situs in its state of domicile, perhaps the only state in which the insurer is licensed, and solicit the purchase of group insurance certificates on a nationwide basis, probably at less expense to itself. Ironically, this approach would be perfectly proper, as it would follow the legal avenue paved for it by the exception advocated in the majority's report. It is argued that this is an extreme example, but the same motives that have in the past impelled some direct mail insurers to design their solicitation material so that it has the appearance of official United States Government mail, from the Department of Defense, or the Social Security Administration, would surely lead them to try any new method, particularly a legal one, as an acceptable alternative to going out of business. Moreover, the effect of the many exemptions proposed by the majority is to carve out from the regulatory system of the several states a multitude of insurance transactions and, for the states of impact, leave these transactions subject to no regulation — and of course no taxation — at all. The NAIC should not place its stamp of approval on model legislation which, while attempting to reduce one problem, creates or leaves an even greater number of unregulated by-products with which the Federal Trade Commission or some other Federal instrumentality might in the future be constrained to deal.

In refusing to review the case of *People v. United National Life Ins. Co.*, 58 Cal. 599, 427 P. 2d 199 (1966), the United States Supreme Court, 389 U.S. 330 (1967), has in effect affirmed the right of the states to require that unlicensed insurers become licensed for the privilege of doing business. A considerable number of states presently have statutes substantially the same as the California statutes at issue in the United National case. We do not believe that the NAIC should take a position which would advise these states, in the form of a model bill, to settle for less than they already have in terms of regulatory authority. As a matter of fact, we would advocate the California statutes involved in the United National case as a workable solution to the unlicensed insurers issue. These statutes contain no exceptions, but as far as we know they have not operated to the serious detriment of any legitimate insurance interest. At two separate points in its report, the majority of the Industry Advisory Committee defines the purpose of an unauthorized insurance regulatory act. At the beginning of Part III the majority says that "The purpose of an unauthorized insurers regulatory act is to

prohibit the transacting of insurance business within a state without a certificate of authority from the regulatory agency."

And at the outset in Part IV A, an unauthorized insurance law is described by the majority as being "designed to protect the interests of a state, its citizens and licensed insurers from the sale of insurance within that state by non-licensed insurers." If these characterizations are valid, as we believe they are, then it would be grossly inconsistent to construct a model bill which would relieve any favored group of unlicensed insurers of the obligation to obtain a license, while at the same time requiring all others to comply with the law.

Respectfully submitted,

H. James Douds,  
General Counsel

To Study Procedures of Reorganization, Receivership and Liquidation  
(D5) Subcom. Report (Mtg. 16)

The Meeting of the Reorganization, Receivership & Liquidation Procedures (D5) Subcommittee met at 11:00 A.M. on June 17, 1968, in the Hilton Hotel in Portland. The Meeting was opened by the Chairman of the Subcommittee, John F. Bolton, Jr. A quorum was present. There followed a general discussion relating to the Liquidation Act which was drafted and presented by the State of Wisconsin.

After extensive discussion the (D5) Subcommittee went into Executive Session and passed the following resolution:

“BE IS RESOLVED that this Subcommittee be kept in existence and expand its study of rehabilitation, liquidation and conservation statutes of other States as well as the act drafted by the State of Wisconsin to the end that a recommendation may be made in the future to the NAIC providing for more common grounds by which all States may conduct their rehabilitation, liquidation and conservation of insurance companies.”

The Subcommittee further agreed to meet in Chicago, at a date prior to the December Meeting of the NAIC, for the purpose of studying the Illinois Manual of Procedure drafted especially for the Illinois Insurance Department's Liquidation Bureau.

Hon. John F. Bolton, Jr., Chm., Ill.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Louis T. Mastos, Nev.; Hon. David M. Pack, Tenn.; Hon. Durwood Manford, Tex.; Hon. Robert D. Haase, Wis.

To Study Administration Experience of the Proxy Regulations and the  
Insider Trading Regulations and Consider Suggested Revisions  
(D6) Subcom. Report (Mtg. 22)

The (D6) Subcommittee To Study Administration Experience of the Proxy Regulations and the Insider Trading Regulations and Consider Suggested Revisions met in Parlor C of the Portland Hilton Hotel on June 17, 1968. A quorum was present.

The Chairman delivered a brief history of the NAIC adoption of an Insider Trading Act and Model Regulations, and an explanation of the proposed amendments to the present Insider Trading Regulations.

The Chairman read the following suggestions received from Commissioner Roddis of California :

1. That the NAIC adopt a penalty for failure to file the necessary papers required by the Insider Trading Law in accordance with Section 32(a) of the Federal Law which provides for a two year imprisonment or a \$10,000 fine for willful failure to comply with the regulations administered by the Securities Exchange Commission;
2. That the NAIC adopt a regulation in the matter of Administration of Proxy Regulations which prospectively adopts any future changes by the SEC and incorporates such into the NAIC regulations, without specific affirmative act of adoption by the NAIC. Such a prospective incorporation of future changes could be conditioned upon a subsequent disapproval procedure by the NAIC, which by passage of time, if not disapproved, would reflect an adoption thereof without further act by the NAIC.

The Chairman also read excerpts from a letter received from Theodore T. Ayervais, Deputy Superintendent and General Counsel of the New York Department:

"Inasmuch as at present no New York domestic insurer has outstanding equity securities which are convertible into another class of equity securities, an amendment of the New York regulation with respect to insider trading along the lines of the SEC Rule 16b-9 would be meaningless. However, for those states which do permit such conversions, such a rule makes sense. The conversion transaction involved results in obtaining another class of equity security which has substantially similar characteristics, the only difference being dividend rights. The proposed rule sufficiently provides against abuses in insider trading in either the convertible equity security or

the security to which the conversion privilege relates within the period of six months. It is the New York Insurance Department policy which, with few exceptions, has been enforced to permit only one class of stock. Consequently, the transaction involved in SEC Rule 16b-8 would not be a matter of concern to this Department. However, as is the case with respect to Rule 16b-9, the proposed exemption was intended to prevent "short swing" profits by insiders unfairly benefiting from information secured by them as result of their position either as director or officer of the insurer or beneficial ownership of more than ten percent of the company stock. What the proposed exemptions would accomplish is to establish a presumption that the two types of transactions covered by these rules are not to be considered as "short swing" transactions. It is made clear that the exemption in these instances is not applicable to any purchase or sale of the securities involved in an exempt transaction within a period of less than six months."

The Chairman read excerpts from a letter received from Superintendent of Insurance, The Honorable Richard E. Stewart of New York:

"I have reviewed the various proposals for consideration and adoption by the (D6) Subcommittee at the June meeting. While, as Mr. Ayervais had indicated in his letter to you, certain of the proposals to add exemptions to the Insider Trading and Proxy Regulations were not applicable in this State, I agree with him that they do make sense.

On the other hand, the proposed exemption with respect to transactions involving the sale of subscription rights would be applicable to situations in New York, and I am in accord with the proposal to amend the Regulation. I have instructed our Office of General Counsel to take the necessary steps to amend our Regulation 45, which deals with insider trading of insurance securities to cover this point.

I note that the Pennsylvania Department is drafting a proposal to have the Insider Trading Regulation apply to holding companies. The subject of holding companies is, as you know, a matter of great interest and importance to us. I await the receipt of a copy of the proposal, so that the New York Department can study the same."

Robert J. Demichelis, representing the American Life Convention and the Life Insurance Association of America, stated that both organizations would endorse the proposed new amendments subject to minor editorial changes. Mr. Demichelis stated that the penalty clause suggested by Commissioner Roddis had been rejected when the original committee studying Insider Trading Law and Regulations proposed the present

Model Act and Regulations. He said the Insider Trading Act is not a criminal statute but is a remedial statute. Mr. Demichelis stated that the American Life Convention would oppose the NAIC's prospectively adopting any future changes in proxy regulations made by the SEC and incorporating these into the NAIC regulations without affirmative action.

In Executive Session, the Subcommittee unanimously adopted the following amendments to the Insider Trading Regulations:

1. Amend Part III by adding a new subparagraph (3) to paragraph (d) of Section 2-2, to read as follows:

Section 2-2. Exemption from Section 2 of Acquisitions of Shares of Stock and Stock Options under Certain Stock Bonus, Stock Option or Similar Plans.

\* \* \* \* \*

(d) \* \* \* \* \*

(3) The term "exercise of an option, warrant or right" contained in the parenthetical clause of the first paragraph of this section shall not include (i) the making of any election to receive under any plan and award of compensation in the form of stock or credits therefore, provided, that such election is made prior to the making of the award; and provided further that such election is irrevocable until at least six months after termination of employment; (ii) the subsequent crediting of such stock; (iii) the making of any election as to a time for delivery of such stock after termination of employment, provided that such election is made at least six months prior to any such delivery; (iv) the fulfillment of any condition to the absolute right to receive such stock; or (v) the acceptance of certificates for shares of such stock.

2. Amend Part III Section 2-5, by revising paragraph (c) to read as follows:

Section 2-5. Exemption from Section 2 of Certain Acquisitions and Dispositions of Securities Pursuant to Mergers or Consolidations.

(c) Notwithstanding the foregoing, if an officer, director or stockholder shall make any purchase (other than a purchase exempted by this Section) of a security in any company involved in the merger or consolidation and any sale (other than a sale exempted by this Section) of a security in any other company involved in the merger or consolidation within any period of less than 6 months during

which the merger or consolidation took place, the exemption provided by this Section shall be unavailable to such officer, director, or stockholder to the extent of such purchase and sale.

3. Amend Part III by amending the Title and substituting a new Section 2-6 to read as follows:

Section 2-6. Exemption from Section 2 of Transactions Involving the Deposit or Withdrawal of Equity Securities Under a Voting Trust or Deposit Agreement.

Any acquisition or disposition of an equity security involved in the deposit of such security under, or the withdrawal of such security from, a voting trust or deposit agreement, and the acquisition or disposition in connection therewith of the certificate representing such security, shall be exempt from the operation of Section 2 of the Act if substantially all of the assets held under the voting trust or deposit agreement immediately after the deposit or immediately prior to the withdrawal, as the case may be, consisted of equity securities of the same class as the security deposited or withdrawn: provided, however, that this section shall not apply to the extent that there shall have been either (a) a purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of such class, or (b) a sale of an equity security of the class deposited and purchase of any certificate representing an equity security of such class (otherwise than in a transaction involved in such deposit or withdrawal or in a transaction exempted by any other provision of the regulations under Section 2 of the Act) within a period of less than six months which includes the date of the deposit or withdrawal.

4. Amend Part III by amending the Title and substituting a new Section 2-7 to read as follows:

Section 2-7. Exemption from Section 2 of Certain Transactions Involving the conversion of Equity Securities.

(a) Any acquisition or disposition of an equity security involved in the conversion of an equity security which, by its terms or pursuant to the terms of the insurer's charter or other governing instruments, is convertible immediately or after a stated period of time into another equity security of the same insurer, shall be exempt from the operation of Section 2 of the Act: provided, however, that this section shall not apply to the extent that there shall have been either (1) a purchase of any equity security of the class convertible (including any acquisition of or change in a conversion privilege) and a sale of any equity security of the class issuable upon conversion, or (2) a

sale of any equity security of the class convertible and any purchase of any equity security issuable upon conversion (otherwise than in a transaction involved in such conversion or in a transaction exempted by any other provision of the regulations under Section 2 of the act) within a period of less than six months which includes the date of conversion.

(b) For the purpose of this section, an equity security shall not be deemed to be acquired or disposed of upon conversion of an equity security if the terms of the equity security converted require the payment or entail the receipt, in connection with such conversion, of cash or other property in connection with such conversion, of cash or other property (other than equity securities involved in the conversion) equal in value at the time of conversion to more than 15 percent of the value of the equity security issued upon conversion.

(c) For the purpose of this section, an equity security shall be deemed convertible if it is convertible at the option of the holder or of some other person or by operation of the terms of the security or the governing instruments.

5. Amend Part III, by adding a new Section 2-8, to read as follows:

Section 2-8. Exemption from Section 2 of Certain Transactions involving the Sale of Subscription Rights.

(a) Any sale of a subscription right to acquire any subject security of the same insurer shall be exempt from the provision of Section 2 of the Act, to the extent prescribed in this Section, as not comprehended with the purpose of said Section of the Act, if:

(1) Such subscription right is acquired, directly or indirectly, from the insurer without the payment of consideration;

(2) Such subscription right by its terms expires within 45 days after the issuance thereof;

(3) Such subscription right by its terms is issued on a *pro rata* basis to all holders of the beneficiary security of the insurer; and

(4) A registration statement under the Securities Act of 1933 is in effect as to each subject security, or the applicable terms of any exemption from such registration have been met in respect to each subject security.

(b) When used within this Section the following terms shall have the meaning indicated:



(1) The term "subscription right" means any warrant or certificate evidencing a right to subscribe to or otherwise acquire an equity security;

(2) The term "beneficiary security" means a security registered pursuant to Section 12 of the Securities Exchange Act, to the holders of which a subscription right is granted;

(3) The term "subject security" means a security which is the subject of a subscription right.

(c) Notwithstanding anything contained herein to the contrary, if a person purchases subscription rights for cash or other consideration, then a sale by such person of subscription rights otherwise exempted by this Section will not be so exempted to the extent of such purchases within the six-month period preceding or following such sale.

6. Amend Part II by labeling the first paragraph (a) and by adding a new subparagraph (b) of Section 1-2 to read as follows:

Section 1-2. Ownership of More than Ten Percent of an Equity Security.

\* \* \* \* \*

(b) In determining for the purpose of Section 1 of the Act whether a person is the beneficial owner, directly or indirectly, of more than ten percent of any class of equity securities, such person shall be deemed to be the beneficial owner of securities of such class which such person has the right to acquire through the exercise of presently exercisable options, warrants or rights or through the conversion of presently convertible securities. The securities subject to such options, warrants, rights or conversion privileges held by a person shall be deemed to be outstanding for the purpose of computing, in accordance with paragraph (a), the percentage of outstanding securities of the class owned by such person but shall not be deemed outstanding for the purpose of computing the percentage of the class owned by any other person. This paragraph shall not be construed to relieve any person of any duty to comply with Section 1 of the Act with respect to any equity securities consisting of options, warrants, rights or convertible securities which are otherwise subject as a class to that section of the Act.

The Subcommittee adopted the following forfeiture provision to be added to the model NAIC Insider Trading Act:

Any insurer which fails to file information, documents, or reports

required to be filed under this Act or any rule or regulation thereunder shall forfeit to the State of \_\_\_\_\_ the sum of \$100 for each and every day such failure to file shall continue. Such forfeiture, which shall be in lieu of any criminal penalty for such failure to file which might be deemed to arise under this Act, shall be payable into the Treasurer of the State of \_\_\_\_\_ and shall be recoverable in a civil suit in the name of the State of \_\_\_\_\_.

The Subcommittee unanimously resolved to recommend to the Laws and Legislation Committee that the Subcommittee be made permanent in order to keep current the Insider Trading and Proxy Regulations of the NAIC.

The Subcommittee agreed to review all SEC amendments to proxy regulations and recommend any needed changes in NAIC regulations on this subject at the December, 1968 NAIC Regular Meeting.

The Chairman suggested the desirability of considering the extension of the principles of the Model Act and Regulations to insurance holding companies and said that he would circulate to the members appropriate amendments to this effect for possible adoption at the December, 1968 NAIC Regular Meeting.

The Subcommittee adopted a proposal to have the Administrative Service Office of the NAIC, when it is properly equipped to do so, act as a clearing house for all insider trading forms sent to the various insurance departments.

There being no further discussion, the meeting was adjourned.

Hon. David O. Maxwell, Chm., Pa.; Hon. Lorne R. Worthington, Ia.;  
Hon. Thomas C. Hunt, Minn.; Hon. Benjamin C. Neff, Jr., Nebr.;  
Hon. Richard E. Stewart, N. Y. by Theodore Ayervais.

COMMISSIONER RODDIS: Mr. President, I move the receipt of the report and, in the absence of any controversy, its adoption.

PRESIDENT BENTLEY: You have heard the motion to receive this report. Is there a second to this motion?

COMMISSIONER BARNES: I'll second it.

PRESIDENT BENTLEY: Is there any discussion? Is there a motion, then, that the report be adopted? There apparently is no concern about the report.

COMMISSIONER HAASE: I so move.

COMMISSIONER PRICE: Second the motion.

PRESIDENT BENTLEY: The motion is made by Commissioner Haase and seconded by Judge Price that the report be adopted. Is there objection to the adoption of the report? The Chair hears none and the report is adopted.

PRESIDENT BENTLEY: The next report is that of the Life, Accident and Health Insurance Committee, (E), headed by Commissioner Williams of Florida, who is not present here but Mr. Ed. Faircloth is recognized.

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LIFE, ACCIDENT AND HEALTH INSURANCE (E) COMMITTEE

AGENDA - MTG. #41

WEDNESDAY P.M.

JUNE 19, 1968

1:30-2:45

BALLROOM A

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Reference

1968 Proc. VOL. I pp. 133-222

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1. Accident and Health Insurance (E1) Subcom. Report (Mtg. 5)
  - Hon. Dudley A. Guglielmo, Chm., La.
  - Hon. Durwood Manford, V.Chm., Texas
  - Refs: 1967 Proc. VOL. II p. 389 (additional references)
  - 1967 Proc. VOL. II pp. 391-394
  - 1968 Proc. VOL. I pp. 137-141
2. Credit Life and Credit Accident & Health Insurance (E2) Subcom. Report (Mtg. 28)
  - Hon. Louis T. Mastos, Chm., Nev.
  - Hon. Robert A. Short, V.Chm., Del.
  - Refs: 1961 Proc. VOL. I pp. 300-305; see pages 508-512 (Model Bill)
  - 1967 Proc. VOL. II p. 389 (additional references)
  - 1967 Proc. VOL. II pp. 395-399
  - 1968 Proc. VOL. I pp. 143-211
3. Fraternal Insurance (E3) Subcom. NMS
  - Hon. George M. Cowden, Chm., Texas
  - Hon. Joseph G. Wood, V.Chm., Ind.
  - Refs: 1967 Proc. VOL. II p. 389 (additional references)
  - 1967 Proc. VOL. II p. 390 NR
  - 1968 Proc. VOL. I p. 134 NR
4. Life Insurance (E4) Subcom. Report (Mtg. 10)
  - Hon. Frank R. Montgomery, Chm., W. Va.
  - Hon. Robert D. Scharz, V.Chm., Mo.
  - Refs: 1967 Proc. VOL. II p. 389 (additional references)
  - 1967 Proc. VOL. II p. 401
  - 1968 Proc. VOL. I p. 213
5. Non-Profit Hospital and Medical Service Associations (E5) Subcom. Report (Mtg. 6)
  - Hon. Lorne R. Worthington, Chm., Iowa
  - Hon. Broward Williams, V.Chm., Fla.
  - Refs: 1967 Proc. VOL. II p. 389 (additional references)
  - 1967 Proc. VOL. II pp. 403-443
  - 1968 Proc. VOL. I pp. 215-220

## 6. Variable Annuities (E6) Subcom. Report (Mtg. 23)

Hon. Robert D. Haase, Chm., Wis.

Hon. James H. Hunt, V.Chm., Vt.

Refs: 1966 Proc. VOL. I pp. 227-233  
 1966 Proc. VOL. II pp. 613-616  
 1967 Proc. VOL. I p. 221  
 1967 Proc. VOL. II pp. 583-584  
 1968 Proc. VOL. I pp. 221-222

## 7. Any other matter submitted for consideration.

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LIFE, ACCIDENT AND HEALTH INSURANCE

## (E) COMMITTEE Report (Mtg. 41)

The Life, Accident and Health Insurance (E) Committee met on June 18, 1968, in Portland, Oregon. A quorum was present.

1. Accident and Health Insurance (E1) Subcom. Report (Mtg. 5)  
 The Chairman called on the Hon. Dudley A. Guglielmo, Chairman of the above Subcommittee, to give his report. Upon the conclusion of the reading of this report, the Chairman of the Subcommittee moved for its adoption. It was moved and seconded and unanimously adopted. A copy of this report is attached hereto.
2. Credit Life and Credit Accident & Health Insurance (E2) Subcom. Report (Mtg. 28)

The Chairman called on the Hon. Louis T. Mastos, Chairman of the above Subcommittee, to give his report. Upon the conclusion of the reading of this report, the Chairman of the Subcommittee moved for its adoption. It was moved and seconded and unanimously adopted. A copy of this report is attached hereto.

## 3. Fraternal Insurance (E3) Subcom.

No report was given as no meeting was held by the Subcommittee during this Meeting.

## 4. Life Insurance (E4) Subcom. Report (Mtg. 10)

The Chairman called on the Hon. Frank R. Montgomery, Chairman of the above Subcommittee, to give his report. Upon the conclusion of the reading of this report, the Chairman of the Subcommittee moved for its adoption. It was moved and seconded and unanimously adopted. A copy of this report is attached hereto.

## 5. Non-Profit Hospital and Medical Service Associations (E5) Subcom. Report (Mtg. 6)

The Chairman called on the Hon. Lorne R. Worthington, Chairman of the above Subcommittee, to give his report. Upon the conclusion of the reading of this report, the Chairman of the Subcommittee moved for its adoption. It was moved and seconded and unanimously adopted. A copy of this report is attached hereto.

6. Variable Annuities (E6) Subcom. Report (Mtg. 23)

The Chairman called on the Hon. Robert D. Haase, Chairman of the above Subcommittee, to give his report. Upon the conclusion of the reading of this report, the Chairman of the Subcommittee moved for its adoption. It was moved and seconded and unanimously adopted. A copy of this report is attached hereto.

Upon the conclusion of the reading and the adoption of these reports, the Committee went into Executive Session.

Chairman Williams called for any other matters to be considered by this Committee.

It was then moved and seconded that the joint report of the Meeting of the (E2) Subcommittee and the (E) Committee held at Las Vegas, Nevada, February 26 and 27, 1968 be made a part of this report. A copy is attached hereto. It was passed unanimously.

There being no further business, the Chairman adjourned the meeting at 2:25 p.m.

Hon. Broward Williams, Chm., Fla.; Hon. T. Nelson Parker, V.Chm., Va.; Hon. Walter S. Houseal, Ala.; Hon. Jerry P. Shea, Ariz.; Hon. Richard S. L. Roddis, Calif.; Hon. J. Richard Barnes, Colo.; Hon. Robert A. Short, Del.; Hon. Albert F. Jordan, D. C.; Hon. James L. Bentley, Ga.; Hon. Joseph G. Wood, Ind.; Hon. Dudley A. Guglielmo, La.; Hon. David J. Dykhouse, Mich.; Hon. Thomas C. Hunt, Minn.; Hon. Robert D. Scharz, Mo.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Charles R. Howell, N. J.; Hon. Richard E. Stewart, N. Y.; Hon. K. O. Nygaard, N. D.; Hon. Eugene P. Brown, Ohio; Hon. Joe B. Hunt, Okla.; Hon. James R. Faulstich, Ore.; Hon. Julio R. Hernandez, P. R.; Hon. James H. Hunt, Vt.; Hon. Robert D. Haase, Wis.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS  
730 Lee Street

Des Plaines, Illinois 60016

April 5, 1968

TO ALL NAIC MEMBERS:

RE: LIFE, ACCIDENT AND HEALTH INSURANCE (E) COMMITTEE  
and  
Credit Life and Credit Accident and Health (E2) Subcom.  
Joint Meeting (2/26-27/68) Report

In accordance with instructions from the Honorable Louis T. Mastos, Chairman of the Credit Life and Credit Accident and Health (E2) Subcommittee, enclosed find copies of the above captioned Reports, including attachments, for your review.

Hugh L. Tollack  
Executive Secretary

HLT/lat  
encs.

cc: Malcolm Moss, American Life Convention  
Walter Runkle, Consumer Credit Insurance Association  
Joseph O'Regan, Health Insurance Association of America  
Eldon Wallingford, Life Insurance Association of America  
Robert Younger, Prudential Insurance Company of America  
Ron Roberts, American National Insurance Company

Life, Accident and Health Insurance (E) Committee  
and Credit Life and Credit Accident and Health  
Insurance (E2) Subcommittee Report, Las Vegas, Nevada

The Executive Session Meeting of the NAIC (E) Committee and (E2) Subcommittee was called to order at 10:00 A.M., Monday, February 26, 1968, in the Board Room, Flamingo Hotel, Las Vegas, Nevada by Commissioner Williams of Florida and Commissioner Mastos of Nevada pursuant to the directive of the NAIC Executive Committee at Honolulu in June 1967.

A Quorum of both Committees was declared present as follows:

(E) COMMITTEE

Hon. Broward Williams, Fla., Chm.	Analyst Ralph Boessen, Missouri
Hon. Walter Houseal, Alabama	Hon. Benjamin C. Neff, Jr., Nebraska
Hon. Jerry Shea, Arizona	Actuary Harold Bittel, New Jersey
Atty. Elward H. Wright, La.	1st Deputy, Geo. Bernstein, New York
Actuary William Conley, Michigan	Asst. Director, Phil Herzing, Ohio
Hon. Thomas C. Hunt, Minnesota	

(E2) Subcommittee

Hon. Louis T. Mastos, Nevada, Chm.	Atty. John Manders, Iowa
Hon. Robert A. Short, Delaware, V.Chm.	Actuary Bill Conley, Michigan
Hon. Walter S. Houseal, Alabama	Analyst Ralph Boessen, Missouri
Hon. Broward Williams, Florida	Actuary, Harold Bittel, New Jersey

In addition to the respective Committee members the following states were represented.

Montana, Illinois, Idaho, and New Mexico

Commissioner Mastos then outlined the purpose of the meeting was that the (E2) Subcommittee had been charged with the responsibility of preparing "the definitive interpretation of that part of the Richmond Resolution dealing with the minimum loss ratio "aka 50% bench mark" as used in the Model Act for Credit Life and Credit Accident and Health Insurance, as per the call of the meeting dated January 22, 1968.

After due discussion it was agreed that the (E) Committee and the (E2) Subcommittee would ask certain industry representatives to appear before them on an individual basis for review of their respective statements on the question as submitted to the members of the committees prior to this meeting. (Copies of their respective statements attached hereto.)

The following industry representatives were then called into the committee room on an individual basis:

1. Malcolm Moss, American Life Convention
2. Walter Runkle, Consumer Credit Insurance Association
3. Joseph O'Regan, Health Insurance Association of America
4. Eldon Wallingford, Life Insurance Association of America
5. Robert Younger, Prudential Insurance Company of America
6. Ron Roberts, American National Insurance Company

At the conclusion of the statements of the above named industry representatives the Committees called on Dr. Peter Feynd from the University of Ohio to give an outline of the Study on Credit Life, Accident and Health Insurance being made by his group. This Study had its inception through the Honorable William Morris, former Director of Insurance for the State of Ohio. Dr. Feynd indicated he hoped to have his Study Report available to Commissioner Mastos prior to the forth coming NAIC Meeting in Portland, Oregon. He urged prompt return of any questionnaires sent forth by his study committee.

Following this report Commissioner Mastos appointed a "Drafting Committee" from the following members of the (E2) Subcommittee:

1. Hon. Robert Short, Delaware, Chm.
2. Frank Alexander, Florida
3. John Manders, Iowa
4. Harold Bittel, New Jersey
5. Ralph Boessen, Missouri

as well as the heretofore named representatives of the four trade associations as an Advisory Committee.

The Drafting Committee was instructed to attempt to draft recommendations for the (E2) Subcommittee in respect to the issues involved in the purpose of this meeting.

A further "Special Committee" was appointed by Commissioner Mastos to outline future projects for the documentation of improvement in the regulation of Credit Life & Accident & Health Insurance and assistance in further improvement of such regulation. This "Special Committee" consists of the following states:

(ref: 1961 Proc. VOL. I pp. 300-305; see pages 503-512 NAIC Model Bill)

1. Hon. Ben Neff, Nebraska, Chm.
2. Earl Nicholson, Nevada
3. Wm. Conley, Michigan
4. George Bernstein, New York
5. Hon. Thomas Hunt, Minnesota
6. Phil Herzing, Ohio
7. Hon. Jerry Shea, Arizona

This was in conformance with NAIC President Bentley's letter to Senator Hart on this matter, under date of January 18, 1968.

The meeting was then recessed at 4:45 P.M. until 10:00 A.M. on Tuesday, February 27th.

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The Executive Session meeting of the NAIC (E) Committee and (E2) Subcommittee was reconvened in the Gold Room of the Flamingo Hotel at 10:00 A.M., Tuesday, February 27th, 1968.

At that time Commissioner Mastos called on the Honorable Robert Short, Chairman of the (E2) "Drafting Committee" for their report.



Commissioner Short presented a proposed resolution and after due discussion thereon certain changes were made therein as suggested by those in attendance with the following final draft thereon as follows:

WHEREAS it has been urged that there be a definitive interpretation of that part of the resolution known as the Richmond Resolution (ref: 1966 Proc. VOL. II pp. 402-403) dealing with the 50% minimum loss ratio benchmark for credit life and credit accident and health insurance adopted by the NAIC at the June, 1966 Meeting in Richmond, Virginia; and WHEREAS it is also desirable to provide additional guidance regarding achievement of that benchmark,

NOW, THEREFORE, the National Association of Insurance Commissioners hereby takes the following action.

1. Reaffirms the Richmond Resolution and urges its prompt implementation by each and every state as the proper and appropriate means of protecting the public against abuses in the conduct of the credit insurance business.

2. Confirms that the promulgation by an individual state of a prima facie acceptable rate or system of rates which produces a loss ratio greater than 50% in the aggregate is not prohibited by the Richmond Resolution or by the NAIC Resolution adopted at the December, 1959 Meeting (ref: 1960 Proc. VOL. I p. 176), reading as follows:

"The Committee in Executive Session recommends to all insurance supervisors that a rate for Credit Life or Credit Accident and Health producing a loss ratio of under 50% should be considered to be excessive."

After due discussion on the proposed resolution it was moved by Commissioner Short that the Report of the "Drafting Committee" be adopted, after a second by the Michigan representative the Report was unanimously adopted by the (E2) Subcommittee.

Commissioner Mastos then called on the Honorable Ben Neff, Nebraska, Chairman of the Special Committee, heretofore referred to herein, for his report. Commissioner Neff outlined the proposed contents of a Statistical Questionnaire to be sent out to all insurance regulatory officials for the purposes of collecting certain information on Credit Life Insurance along the lines requested by Commissioner Dykhouse of Michigan in his recent letter to all members of the respective committees. Nebraska will compile the information and present same to Commissioner Mastos prior to the June Meeting in Portland. Harold Bittel moved for its adoption; Honorable Broward Williams seconded the motion and it was passed unanimously.

Commissioner Mastos, Chairman of the (E2) Subcommittee then turned the meeting over to the Honorable Broward Williams, Chairman of the (E) Committee.

Commissioner Williams then called on Commissioner Mastos for the adopted Resolution and Report of the (E2) Subcommittee. Upon submission thereof Commissioner Mastos moved for its adoption, and upon a second by Harold Bittel of New Jersey, the Report was adopted by the (E) Committee for presentation to the Executive Committee and Plenary Session at the June Meeting of the NAIC.

There being no further business before the Joint Meeting of these Committees, the meeting was adjourned.

#### (E) COMMITTEE

Hon. Broward Williams, Chm., Fla.; Hon. T. Nelson Parker, V.Chm., Va.; Hon. Walter S. Houseal, Ala.; Hon. G. A. Bushnell, Ariz.; Hon. Richard S. L. Roddis, Calif.; Hon. J. Richard Barnes, Colo.; Hon. Robert A. Short, Dela.; Hon. Albert F. Jordan, D. C.; Hon. James L. Bentley, Ga.; Hon. Joseph G. Wood, Ind.; Hon. Dudley A. Guglielmo, La.; Hon. David J. Dykhouse, Mich.; Hon. Thomas C. Hunt, Minn.; Hon. Robert D. Scharz, Mo.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Charles R. Howell, N. J.; Hon. Richard E. Stewart, N. Y.; Hon. K. O. Nygaard, N. D.; Hon. William R. Morris, Ohio; Hon. Joe B. Hunt, Okla.; Hon. James R. Faulstich, Ore.; Hon. Julio R. Hernandez, P. R.; Hon. James H. Hunt, Vt.; Hon. Robert D. Haase, Wis.

#### (E2) Subcommittee

Hon. Louis T. Mastos, Chm., Nev.; Hon. Robert A. Short, V.Chm., Del.; Hon. Walter S. Houseal, Ala.; Hon. J. Richard Barnes, Colo.; Hon. Broward Williams, Fla.; Hon. Lorne R. Worthington, Iowa; Hon. David J. Dykhouse, Mich.; Hon. Robert D. Scharz, Mo.; Hon. Charles R. Howell, N. J.; Hon. James R. Faulstich, Ore.; Hon. Charles W. Gambrell, S. C.; Hon. James H. Hunt, Vt.; Hon. Frank Montgomery, W. Va.

STATEMENT OF THE AMERICAN LIFE CONVENTION  
to the  
CREDIT LIFE AND CREDIT ACCIDENT AND HEALTH INSURANCE  
(E2) Subcommittee  
and the  
LIFE, ACCIDENT AND HEALTH INSURANCE (E) COMMITTEE  
for their  
MEETING ON FEBRUARY 26 AND 27, 1968,  
IN LAS VEGAS, NEVADA

February 14, 1968

STATEMENT ON THE NAIC - RECOMMENDED 50%  
LOSS RATIO BENCHMARK

The American Life Convention (ALC) respectfully submits this statement in response to the invitation so to do of Chairman Louis Mastos of the (E2) Subcommittee. Our association represents 343 life insurance companies in the United States and Canada. These companies presently have about 92% of the total non-governmental life insurance and approximately 80% of all credit life insurance in force in this country. One set of published figures indicates these companies also receive about 75% of the total premium income from credit health insurance.

We have largely limited our comments herein to the specific issue before your Subcommittee and Committee, as stated in the notice calling this joint meeting. This issue was before the December, 1967, meeting of the Executive Committee of the NAIC in the form of a request by the Federal Liaison Committee for "a definitive interpretation from the Executive Committee as to the meaning of that part of the Richmond Resolution," thus referring to the NAIC-recommended 50% loss ratio. At that time the Executive Committee referred the request to your (E2) Subcommittee. In presenting our views about "interpreting" the 50% minimum loss ratio, we should say at the outset that there is only one interpretation possible, in view of the facts surrounding its adoption and its unqualifiedly accepted meaning over the ensuing years. We also believe it essential to point out that no question has been raised before the NAIC previously as to the interpretation of this benchmark. As a matter of fact, except for very recently no one thought there was any need for "interpreting" what was apparently thought to be plain and unambiguous.

Obviously, the NAIC has the power and right to adopt a different benchmark, or change the percentage in this benchmark, if it sees fit to do that by appropriate action. It is our feeling, very simply, however, that the benchmark should not be changed by "interpretation." If the benchmark is to be superseded or changed, that should be accomplished by direct and frank action, not by attributing to it a new, unjustified meaning — one which was never intended at its adoption or which is contrary to its application and use in all of the over eight years since its adoption.

In arriving objectively at the determination of what the NAIC meant by the "50% minimum loss ratio benchmark" as that phrase is used in the Richmond Resolution, we must look to the meaning of the benchmark at the time of its adoption in 1959 and the basis of its acceptance since that time, as disclosed "by the record" and by general knowledge. It is clear that the NAIC adopted the reference to the benchmark in the Richmond Resolution in the context of both the 1959 Resolution adopting that benchmark and Section 7B of the NAIC Model Bill for the Regulation of Credit Life and Credit Accident and Health Insurance. All references to and uses of the 50% minimum loss ratio are directly in the implementation of that Section 7B, wherein authority is given the supervisory official to disapprove policy forms "if the benefits provided therein are not reasonable in relation to the premium charged . . ." The Richmond Resolution gives the benchmark no new or different meaning. All the Richmond Resolution did with respect to the benchmark was, in effect, to incorporate it by reference just as it was adopted by the NAIC in 1959, with its meaning when so adopted and as understood and applied in the intervening six and a half years.

The Richmond Resolution identifies the benchmark and incorporates it for further references in its opening preamble:

"WHEREAS the NAIC *has gone on record* in favor of the application of a

*50% minimum loss ratio benchmark* in implementing the requirement of Section 7B of the Model Bill For the Regulation of Credit Life and Credit Accident and Health Insurance that there be a reasonable relationship between benefits and premiums;" (italics added) (1966 NAIC Proceedings Vol. II pp. 402-403).

As noted in the official NAIC Proceedings, this Resolution was offered by the Consumer Credit Insurance Association and supported by our association, as well as the Life Insurance Association of America (LIAA) and the Health Insurance Association of America. Prior to the June, 1966, meeting at which the Richmond Resolution was adopted by the NAIC, it had been approved by the ALC-LIAA Joint Legislative Committee, a joint policy-making body for our organization and the LIAA, as one of the "recommendations that had been developed by the [Joint ALC-LIAA] Subcommittee on State Regulatory Matters with regard to the NAIC 50% loss ratio benchmark, designed to insure more effective state supervision of credit insurance rates." (Minutes of the May, 1966, meeting of ALC-LIAA Joint Legislative Committee). It should be noted that the word "minimum" was not used in this reference. In approving the Richmond Resolution there obviously was not the slightest doubt then as to the identity of the 50% loss ratio benchmark described in it — it was clearly understood as the one approved by the NAIC Resolution of 1959.

There are two periods of time during which statements by regulatory officials on the meaning of the "benchmark" are illuminating and pertinent: the period immediately preceding the NAIC Resolution of 1959 adopting the "benchmark", and the period of intervening years between then and the adoption of the 1966 Richmond Resolution, during which the "benchmark" was unqualifiedly accepted and followed by insurance department personnel in various states and broadly supported by the industry.

It will be recalled that the NAIC approved the Model Bill at its December, 1957, meeting. In February, 1958, Commissioner Larson of Florida, as Chairman of the Committee on Installment Sales and Loans, a forerunner of the (E2) Subcommittee, appointed a special subcommittee to implement the Model Bill chaired by Director Gerber of Illinois. That subcommittee first met March 24-25, 1958, in Miami Beach, Florida, and the subject of a "benchmark" for use in guiding supervisory officials in exercising their discretion under Section 7B of the Model Bill was considered. There was considerable controversy at that meeting over this subject, with one segment of the industry recommending a 40% loss ratio benchmark and another segment arguing that a higher benchmark was required. Commissioner Sheehan of Minnesota, a member of the subcommittee, indicated that he was opposed to the "benchmark" idea, but was thinking in terms of 50%, with allowances for special circumstances. Another subcommittee member, Director Binning of Nebraska, said that, as a yardstick, he would require that the insured receive back as much as the company and the agent receive, or in other words, that the commissions, expenses and profit, etc., could not be greater than the amount paid out in claims. [Earlier statements referring to the 40% and 50% "benchmarks" may also be found in 1958 NAIC Proceedings, Vol. I, pp. 146-147.] It was very clear at this point that all concerned were in agreement that the "benchmark" under consideration was quite specific, rather than a widely variable, loss ratio which could be used as a principle for determining reasonableness of premiums.

The NAIC Resolution adopted at the December, 1959, meeting is as follows:

"The Committee in Executive Session recommends to all insurance supervisors that a rate for Credit Life or Credit Accident and Health producing a loss ratio of under 50% should be considered to be excessive." (1960 NAIC Proceedings Vol. I, p. 176.)

It will be observed that the carefully developed wording of the Resolution patently provides a conclusion that a premium rate which produces a 50% loss ratio is not excessive.

Although the 1959 Resolution does not contain the word "minimum" any place within it, subsequent references to the 50% loss ratio rather frequently have included the word "minimum." This is of no significance as an interpretation or change of the benchmark. Such references undoubtedly are due to the particular language of the Resolution to the effect that any rate producing ". . . under 50% . . ." should be considered excessive, and the fact of the benchmark's continued application and acceptance corroborate its continuing 2-times-claims-costs meaning.

As illustrative of the meaning of the 50% minimum loss ratio benchmark as understood and applied by supervisory officials since 1959, we refer you to an analysis of proposed amendments to the Model Bill prepared by the New York Insurance Department and submitted to the Credit Life and Credit Accident and Health Model Bill Legislation Subcommittee in 1960. (1961 NAIC Proceedings Vol. I, pp. 294-298.) The second from last paragraph of that analysis is quoted herewith as a lucid, unequivocal ex-

pression of the understanding of the 50% minimum loss ratio by the New York Department at that time (although that Department was questioning the desirability of using the benchmark in the paragraph):

"To illustrate the actuarial unsoundness of the single yardstick, let us take two cases, *assuming the use of a 50% loss ratio in both*. In one case, we have a premium rate of 50 cents per hundred of initial indebtedness for a loan repayable in 12 equal monthly installments. The premium rate for this purpose is presumed to be based upon credible experience producing a 50 per cent loss ratio, thus leaving a margin of 25 cents available for commissions, allowances, other sales costs, dividends or experience-rating refunds, home office administration expense and profit. In the second case, we have a \$1 rate, also presumed to be based on credible experience producing a 50% loss ratio. Here, 50 cents or twice as much as in the first case is available for commissions, allowances, etc. Obviously, the fact that the pure mortality cost in the second case is twice that in the first case is no justification for *doubling the margin available for distribution to the creditor, agent and insurer.*" (italics added)

That this interpretation given the 50% minimum loss ratio benchmark in 1960 was correct was later confirmed by New Jersey's Chief Actuary, W. Harold Bittel, in the so-called "New Jersey Analysis" of the 1964 Mortality and Morbidity Experience Study. (1964 NAIC Proceedings, Vol. II, pp. 508-512.) Note, for example, the statement in the tenth paragraph of that Analysis (see page 510 of the 1964 NAIC Proceedings):

"One objective of the study was to find benchmarks against which the reasonableness of levels of premiums and charges could be measured. The 50% minimum loss ratio recommendation of the NAIC means that at least one-half of the premium charge must be used to pay claims and that a premium rate substantially in excess of *twice the claim rate* cannot be considered reasonable." (italics added)

Although, it may be recalled, the Arizona Insurance Department disagreed with the Analysis referred to above and submitted one of its own, that Department was also in agreement with the proposition that determination of maximum prima facie acceptable rates based on the 50% minimum loss ratio principle was simply a matter of multiplying 2 times the claims cost per \$100, (1965 NAIC Proceedings, Vol. I, pp. 140-144.)

We also are confident that many records of hearings and of actions in the insurance departments of various states over the years buttress our position, except for a few arguments included therein and presented by a part of the business within the last year, which arguments are really for a new, convenient "interpretation" actually constituting a new or changed benchmark. That convenient "interpretation" presents a version of the benchmark which its proponents in retrospect now wish had been adopted by the NAIC — not what was adopted and repeated in the Richmond Resolution. This has been an indirect attempt to seek a change, thus avoiding a direct attempt to change the benchmark. The benchmark, however, cannot be and has not been changed by these arguments or "interpretations."

We have not commented hereinbefore on the manner of use, or the translation into dollars-and-cents premium rates, of the 50% loss ratio. The notice of this meeting does not bring any question about the translation process before you here. Nevertheless, because we believe you may be interested, at least indirectly, and because others may take this occasion to go beyond the stated issue in presenting their views, we present our position on this regulatory procedure by directing your attention to the attached copy of the resolution, which was adopted on June 8, 1967, by the ALC Executive Committee, particularly paragraph 2 and 3 on page 2 thereof.

#### SUMMARY

In adopting the Richmond Resolution in June, 1966, the NAIC clearly had in mind the very same 50% loss ratio which had been the focus of attention since its promulgation as a benchmark in 1959. Nowhere in the Proceedings of the NAIC prior to 1959 or since then, at least until December, 1967, does there appear any doubt as to what was intended by the benchmark — that in determining the reasonableness of the relationship between premium rates and benefits and, accordingly, in setting maximum prima facie, or presumptively acceptable, premium rates, supervisory officials were urged to follow the principle of multiplying by two the relevant credible claims cost experience. Prior to adoption of the 50% loss ratio as a benchmark, there was considerable debate as to what that particular benchmark should be — 40%, 50%, 60%, etc. It undoubtedly is true, as has been stated by knowledgeable persons in the industry, that 50% was a compromise percentage. Be that as it may, the important point is that the 50% loss ratio was the "benchmark" adopted by the NAIC, and incorporated in the Richmond Resolution, the basis for measuring the reasonableness of premium rates in relation

to benefits and thereby controlling maximum prima facie premium rates and, until another percentage is substituted in the principle, or another basis for implementing Section 7B is adopted, no "interpretation" at this time can change the facts from what they are. By its very terms, the benchmark proclaims that a premium rate which produces a lesser loss ratio than 50% is excessive and thereby, in the context of its adoption and in its long, wide acceptance, equally supports the proposition that a premium rate which produces a 50% loss ratio is not excessive. It seems unalterably certain that the benchmark requires a loss ratio of not less than 50% but also contemplates one in some proximity to that percentage. The Richmond Resolution, by using the term "50% minimum loss ratio", did not change the benchmark in any way. Its limitation and meaning as a 2-times-claims-cost formula or benchmark continues unaltered.

Our position on use or translation of the benchmark into premium rates is stated in the following resolution, particularly paragraphs 2 and 3 on page 2 thereof.

Respectfully submitted,  
C. Malcolm Moss  
General Counsel  
American Life Convention

Resolution Adopted by the American Life Convention

Executive Committee June 8, 1967

**RESOLVED:** That the American Life Convention affirms again its support of effective state regulation of credit life and credit accident and health insurance thus reaffirming its earlier support of the resolution relating to the regulation of credit life and accident and health insurance adopted by the National Association of Insurance Commissioners at its 1966 Annual Meeting as being in the public interest. The Convention further declares that it is desirable that efforts be made to control more effectively the premium rates charged for such coverages.

The Convention recognizes that the Board of Directors of the Life Insurance Association of America has adopted a policy position in effect urging adoption of a prima facie rate of sixty cents per \$100 of initial indebtedness as the proper prima facie rate for credit life insurance to be promulgated by all state insurance regulators in implementation of the 50% minimum loss ratio benchmark recommended by the National Association of Insurance Commissioners.

Therefore, it is the position of the American Life Convention that in those states where all the relevant information available to the Commissioners indicates that such a prima facie rate is consistent with the 50% minimum loss ratio benchmark, it should be supported but in those jurisdictions where a different prima facie rate is appropriate because the relevant statistical and other information with respect to claim costs or experience calls for a different rate, whether lower or higher than sixty cents per \$100 of coverage, then staff is directed to support that different rate.

More specifically, the American Life Convention reaffirms and adopts the following:

1.— Diligent and vigorous action shall be taken to seek to achieve the following:

- A. Enactment of the NAIC Model Bill to Provide for the Regulation of Credit Life and Credit Accident and Health Insurance in all states where it has not been enacted.
- B. The implementation by each State Insurance Commissioner, who has not done so, of Section 7B of the NAIC Model Bill, or other similar provision of law, by the adoption of the 50% minimum loss ratio benchmark and its enforcement.
- C. The promulgation, by the Insurance Commissioners having the authority so to do, after notice and hearing, of maximum prima facie premium rates applicable to specified plans of benefits, terms of coverage, and conditions under which the coverage is made available, which all insurers will be permitted to charge until such premium rates are changed.
- D. Adoption by the Insurance Commissioners, who promulgate such prima facie maximum premium rates, of a reasonable and simple procedure under which deviations from such premium rates may be obtained, including a reasonable system for consideration of an insurer's own experience or its expected experience on a case, or on a class of business,

or assumptions based on the comparable experience of other insurers in supporting expected experience.

- E. The periodic review by the Insurance Commissioners of credit insurance statistics becoming available in future NAIC studies and other relevant studies or statistics, and the adjustment as necessary of such prima facie maximum premium rates, or the benefits provided, and such deviations procedures to the end that loss ratios consistent with the 50% minimum loss ratio benchmark will be maintained.
- 2.— In promulgating prima facie maximum premium rates, the Insurance Commissioners should give great weight to the 1964 NAIC Mortality and Morbidity Study which demonstrates a nationwide average credit life insurance claim cost of approximately 30¢, but the Commissioners should also consider all other relevant statistical and other information with respect to claim costs or experience, including that contained in the Credit Life and Accident and Health Exhibit of each company, that developed by their respective Insurance Departments or submitted to them, and that pertaining to claim costs or experience developed in their respective states.
- 3.— In translating the 50% minimum loss ratio into specific prima facie maximum premium rates, the Insurance Commissioners should so act (consistent with 2.— above) as to eliminate or minimize to the greatest extent possible any effect of such rates tending to produce what is commonly called competition in reverse.

**MEMORANDUM TO:** Members of the NAIC (E) Committee  
and (E2) Subcommittee

**FROM:** Walter D. Runkle, General Counsel  
Consumer Credit Insurance Association  
307 North Michigan Avenue  
Chicago, Illinois 60601

**RE:** Interpretation of the 50% Loss Ratio Benchmark

In 1957, the NAIC completed its draft of the Model Bill for the Regulation of Credit Life and Credit Accident and Health Insurance (Vol. I, 1958 Proceedings of the NAIC, page 106). This Bill provided the insurance commissioner with authority to disapprove a company's forms if the benefits provided therein are not reasonable in relation to the premium charge (See Section 7.B. of the NAIC Model Bill). It was early recognized that the NAIC Model Bill language should have a uniform method of enforcement and the NAIC considered what standard might be recommended to accomplish the uniformity. In 1959, the NAIC adopted the following resolution:

"The committee in executive session recommends to all insurance supervisors that a rate for Credit Life or Credit Accident and Health, producing a loss ratio of under 50% should be considered to be excessive." (Vol. I, 1960 Proceedings of the NAIC, page 176).

The discussion surrounding the adoption of this Resolution clearly indicated that a rate for Credit Life or Credit Accident and Health Insurance which would produce a loss ratio of 50% would be considered reasonable. The language of the Resolution impels this conclusion. If a loss ratio of under 50% should be considered excessive, the converse would have to substantiate the view that a loss ratio of 50% should be considered to be reasonable.

In 1966, the NAIC adopted the so-called Richmond Resolution (Vol. II, 1966 Proceedings of the NAIC, pages 402-403). This Resolution in the very first sentence refers to the NAIC 1959 Resolution, defining it as a 50% minimum loss ratio benchmark. The adjective "minimum" was used to describe the 1959 Resolution because the 1959 Resolution states that a rate which produces a loss ratio of under 50% should be considered to be excessive. In other words a loss ratio of 50% was necessary in order for the rate to be reasonable and the word "minimum" accomplished this understanding. In no instance was it suggested or is it stated that the term "50% minimum loss ratio benchmark" means anything other than the 1959 Resolution. As a matter of fact, Paragraph 4 of the Richmond Resolution states: "Insurers which produce loss ratios of less than 50% should be required to explain the reasons therefor." This sentence carries through the clear understanding of the proponents of the Richmond Resolution that a loss ratio of 50% would be acceptable as reasonable and within the intent of the "50% minimum loss ratio benchmark."

It is now contended that the Richmond Resolution recommends to the individual insurance supervisors the adoption of any loss ratio benchmark which produces or is likely to produce loss ratios higher than 50%. This is not what was intended nor what the Richmond Resolution states. As mentioned before, the term "50% minimum loss ratio benchmark" specifically refers to the NAIC 1959 Resolution and must be read in light of that language.

The problem of interpretation results from a change of position by some proponents of the Richmond Resolution who are attempting a strained construction of the clear meaning of the 1959 and 1966 Resolutions. We believe the Resolutions are clear but if a definitive interpretation is necessary it can be accomplished by stating the converse to the 1959 Resolution which was intended and is implicit:

A rate for Credit Life or Credit Accident and Health Insurance producing or which can reasonably be expected to produce a loss ratio of 50% should be considered to be reasonable.

Statement of the Health Insurance Association of America  
to the NAIC Credit Life and Credit Accident and Health  
Insurance (E2) Subcommittee and the Life, Accident and  
Health Insurance (E) Committee for Consideration at the  
NAIC Meetings in Las Vegas, Nevada on February 26 and 27, 1968

HIAA STATEMENT ON NAIC 50% CREDIT INSURANCE  
BENCHMARK RECOMMENDATION

The Health Insurance Association of America, a national trade association of 334 insurance companies writing approximately 90% of the group health insurance business and approximately 80% of the individual insurance business written in the United States, submits the following statement in response to the invitation extended by The Honorable Louis T. Mastos, Insurance Commissioner of the State of Nevada, in his capacity as Chairman of the NAIC (E2) Subcommittee, meeting in Las Vegas, Nevada on February 26 and 27, 1968, to consider the question referred to the NAIC (E2) Subcommittee by the NAIC Executive Committee as the result of the request of the NAIC Federal Liaison Committee for ". . . a definitive interpretation from the Executive Committee as to the meaning of that part of the Richmond Resolution", which refers to the NAIC recommended loss ratio benchmark. (Page 2 NAIC Executive Committee Report, Honolulu meeting.)

HISTORY OF ORIGIN OF THE RICHMOND RESOLUTION

As Insurance Commissioners gained experience through the early sixties in attempting to design fair and equitable regulations for the implementation of the NAIC Model Credit Bill, there developed several areas of practices which the individual Insurance Commissioners, during and after public hearings, indicated to the insurance business that there was some need for additional NAIC recommended guidelines on such practices and, as a result, the insurance business made certain recommendations to the NAIC at the Richmond NAIC meeting, and those recommendations were embodied in what is now commonly referred to as the Richmond Resolution. All of those items on which recommendations were made by the business in response to such requests from individual Insurance Commissioners were embodied in the Richmond Resolution, but perhaps it would be helpful to summarize the items enumerated in the Richmond Resolution.

The Richmond Resolution, in substance, contains the following recommendations:

The four preambles of the Richmond Resolution refer to:

- (1) The previously established loss ratio benchmark. (It is apparent this reference is to the 1959 NAIC Resolution. There was no other NAIC recommended benchmark for credit insurance.);
- (2) The NAIC had previously rejected (while the Model Bill was in the drafting stage) control of compensation to creditors as a supplementary means of implementing Section 7 B of the NAIC Model Bill;
- (3) That questions had been raised recently concerning the propriety of controlling commissions, dividends, retrospective rate credits or experience rating refunds, and all other forms of compensation to the creditors, and
- (4) Such methods of attempting to control compensation to creditors had proved ineffective and had unintended and undesirable consequences.

After the preamble, the Richmond Resolution briefly recommended:

- (1) Enactment of the Model Credit Bill in states where it had not been enacted;
- (2) Implementation of Section 7 B of the Model Bill by the adoption of the 50% minimum loss ratio benchmark, and its enforcement;
- (3) The establishment by the Commissioner of prima facie acceptable rates applicable to specified plans and benefits;
- (4) The adoption of a reasonable and simple procedure under which deviations may be obtained;
- (5) The use of all relevant information available in the establishment of rates or in the granting of deviations;



- (6) That insurers which produce loss ratios of less than 50% should be required to explain the reasons therefor;
- (7) Periodic review of credit insurance statistics and, after notice and hearing, adjust as necessary:
  - (a) The level of prima facie acceptable rates;
  - (b) The procedure under which deviations may be obtained; and
- (8) That the NAIC continue its efforts to obtain Morbidity statistics at the earliest possible date.

Prior to the Richmond NAIC meeting, commencing in January 1966, the Insurance business held numerous meetings for the purpose of discussing the proposed Richmond Resolution. I mention this to assure you that the Richmond Resolution has perhaps received more discussion and resulted in more Industry Committee meetings than any other item relating to credit insurance and, certainly, if it had been the intention of the insurance business to change by the Richmond Resolution the meaning of the interpretation of the NAIC 1959 Loss Ratio Benchmark Resolution, such a controversial item would have been discussed in great detail on numerous occasions, and it was never discussed in such meetings. Such a lack of discussion is extremely important in any effort to determine the intention of the drafters of the Richmond Resolution.

#### INTERPRETATION OF THE RICHMOND RESOLUTION

Since the preamble, or paragraph, in the Richmond Resolution (ref: 1966 Proc. Vol. II, pp. 401-406, see pages 587-588) refers to the then established NAIC loss ratio benchmark, it is necessary in interpretation of the Richmond Resolution to refer to the language of the NAIC 1959 Resolution (ref: 1960 Proc. Vol. I pp. 175-177; 180; see pages 588-589), and to the discussions which preceded the adoption of the NAIC 1959 Resolution. When the NAIC 1959 Resolution is reviewed in the light of the NAIC discussions which preceded the adoption of the 1959 NAIC Resolution, it is clear, just from a reading of the NAIC Proceedings, that there was substantial disagreement, at that time, as to whether the loss ratio benchmark should be 40%, 50% or 60%. It is apparent from a review of the NAIC Proceedings that the NAIC in 1959 rejected the 40% recommendation and rejected the 60% recommendation and adopted the 50% recommendation. Certainly, if the NAIC by the adoption of the Richmond Resolution intended to change the meaning of the 1959 NAIC Resolution which established the 50% loss ratio benchmark, it would have removed or modified the first paragraph of the Richmond Resolution which refers to the then established NAIC benchmark. The removal or modification of the language in the first paragraph would have generated substantial discussion at the Richmond NAIC meeting, and the absence of the removal or modification of the language in the first paragraph of the Richmond Resolution is tangible evidence that the Industry did not intend to change by submission of the Richmond Resolution and the NAIC did not intend to change, by the adoption of the Richmond Resolution, the 50% loss ratio benchmark contained in the NAIC 1959 Resolution.

The NAIC 1959 Resolution was adopted by the NAIC Insurance Covering Installment Sales and Loans Committee after the NAIC Credit Life and Credit Accident and Health Model Bill Legislation Subcommittee had put the matter over for further study. Some of you were present at and remember that the 1959 Miami Beach meeting of the NAIC Credit Life and Credit Accident and Health Model Bill Legislation Subcommittee, which considered the adoption by the NAIC of a recommended loss ratio benchmark, was an extremely controversial meeting. When the NAIC Credit Life and Credit Accident and Health Model Bill Legislation Subcommittee adjourned at the 1959 Miami Beach meeting without adopting a recommended benchmark, it was assumed by most of the persons present at the meeting that the NAIC would not adopt a recommended loss ratio benchmark at the Miami Beach meeting; however, as the National Underwriter articles indicate, and other news articles available indicate, the Industry urged the Parent Committee, the Insurance Covering Installment Sales and Loans Committee, to get on with the task of recommending an NAIC Loss Ratio Benchmark for Credit Insurance. The Parent Committee, as indicated in the attached Parent Committee Report and in the news reports of the 1959 meeting, adopted the NAIC 1959 Loss Ratio Benchmark Resolution.

#### CONCLUSION

If the NAIC desires to change its recommended 50% loss ratio benchmark, we hope it is not changed by interpretation only. If the 50% loss ratio benchmark is to be changed, it should be changed by affirmative direct language and by the adoption of an NAIC Resolution which clearly states any such new benchmark. Otherwise,

in the future, the NAIC or others could, by interpretation, change again the meaning of the Richmond Resolution.

Respectfully submitted,

F. Joseph O'Regan  
Associate General Counsel  
Health Insurance Association of America

Credit Life and Credit Accident and Health Insurance

(E2) Subcom. Report Mtg. #21

(ref: 1966 Proc. Vol. II pp. 401-403)

A meeting of the Subcommittee on Credit Life and Credit Accident and Health Insurance was held in the Dominion Room of the John Marshall Hotel, Richmond, Virginia on Monday, June 20, 1966. A quorum was present. The only pending item on the agenda for this Subcommittee was that of the Subcommittee to Study Mortality and Morbidity Experience of Credit Life and Credit Accident and Health Insurance (E2a). A report was made by Mr. Harold Bittel, New Jersey, on the status of the work of this Subcommittee. Mr. Bittel extended an invitation to any company who so desires to participate in the work of this Subcommittee by agreeing to supply the necessary statistical data. Mr. Bittel reported that the question of financing the work of this Subcommittee is presently unresolved. Mr. Bittel recommended that the Subcommittee request the industry Advisory Committee to propose a plan by which the industry might be solicited to make voluntary contributions toward the cost of the processing of the study.

A resolution was presented to the Subcommittee by Mr. Walter Runkle representing the Consumer Credit Insurance Association. (A copy of the resolution presented by Mr. Runkle is incorporated in this report.) Agreement with the resolution offered by Mr. Runkle was expressed by Mr. Malcolm Moss, American Life Convention. Mr. Joseph O'Regan, Health Insurance Association of America and Mr. Albert Pike, Life Insurance Association of America.

In Executive Session, the resolution presented by Mr. Runkle was adopted by the Subcommittee with Alabama, Connecticut, Delaware, Florida, Maine, New Jersey and Oregon voting in favor. South Carolina abstained.

There being no further matter before the Subcommittee, it was declared adjourned.

Hon. Walter S. Houseal, Chm., Ala.; Hon. Robert D. Scharz, V.Chm., Mo.; Hon. William R. Cotter, Conn.; Hon. Robert A. Short, Del.; Hon. Broward Williams, Fla.; Hon. George F. Mahoney, Maine; Hon. Louis T. Mastos, Nev.; Hon. Charles R. Howell, N. J.; Hon. K. O. Nygaard, N. D.; Hon. Walter G. Korlann, Ore.; Hon. Charles W. Gambrell, S. C.

WHEREAS the NAIC has gone on record in favor of the application of a 50% minimum loss ratio benchmark in implementing the requirement of Section 7B of the Model Bill For the Regulation of Credit Life and Credit Accident and Health Insurance that there be a reasonable relationship between benefits and premiums; and

WHEREAS in adopting the Model Bill the NAIC rejected recommendations that compensation to creditors, in connection with credit life and credit accident and health insurance covering debtors of such creditors, be limited and instead adopted the requirement of Section 7B of the Model Bill that there be a reasonable relationship between benefits and premiums; and

WHEREAS questions have been recently raised concerning the propriety of implementing Section 7B of the Model Bill and the 50% minimum loss ratio benchmark by placing limits upon the amount of compensation to creditors and/or agents by way of commissions, dividends, retrospective rate credits, experience rating refunds and all other forms of compensation to creditors; and

WHEREAS such limitations may appear to have merit, but have been found to be ineffective in implementing Section 7B of the Model Bill and the 50% minimum loss ratio benchmark and therefore ineffective in protecting the public's interest and on the contrary have been found in practice to have unintended and undesirable consequences,

NOW THEREFORE the National Association of Insurance Commissioners recommends to the Commissioners of the individual states;

1. Enactment of the NAIC Model Bill to Provide for the Regulation of Credit

Life and Credit Accident and Health Insurance in all states where it has not been enacted.

2. The implementation of Section 7B of the Model Bill by the adoption of the 50% minimum loss ratio benchmark and its enforcement.
3. As a simplified method of achieving and enforcing the 50% minimum loss ratio benchmark, concurrently and dependently, both
  - (a) the promulgation by the Commissioner of each state, after notice and hearing, of prima facie acceptable rates applicable to specified plans of benefits, terms of coverage and conditions under which the coverage is made available, which all insurers will be permitted to charge until such rates are changed, and
  - (b) the adoption of a reasonable and simple procedure under which a deviation from such prima facie acceptable rates may be obtained, including a reasonable system for review of such deviations. Such procedure shall take into consideration an insurer's own experience or its expected experience on a case, or a class of business, or assumptions based on the comparable experience of other insurers in supporting expected experience.
4. As a means of achieving control of the operation of the prima facie acceptable rates and the deviation procedure, the use of information now available in the Credit Life and Accident and Health Exhibit of each company and other relevant information. Insurers which produce loss ratios of less than 50% should be required to explain the reasons therefor.
5. The periodic review of credit insurance statistics becoming available in future NAIC studies and other relevant studies or statistics and of the information developed under 4 above. Based upon such reviews, the Commissioner, after notice and hearing, should adjust as necessary,
  - (a) the level of prima facie acceptable rates and/or the plans of benefits, terms of coverage and conditions under which the coverage is made available to which such prima facie acceptable rates are applicable,
  - (b) the procedure under which deviations from such prima facie rates may be obtained,

so that loss ratios consistent with the 50% minimum loss ratio benchmark will be maintained.

IT IS URGED, in view of the extreme importance of this matter, that the foregoing recommendations be promptly implemented.

WHEREAS the Commissioners have available the credit life insurance statistics from the NAIC 1964 Study and other relevant studies or statistics it is urged that they be utilized as a basis for determining prima facie acceptable rates for credit life insurance.

WHEREAS the NAIC 1964 Study did not produce credible morbidity statistics for credit accident and health business,

IT IS URGED for credit accident and health insurance that:

- (i) The NAIC Subcommittee to Study Mortality and Morbidity Experience of Credit Life and Credit Accident and Health Insurance continue its current efforts to obtain such statistics at the earliest possible date.
- (ii) As an interim measure, pending the availability of such statistics, that the Commissioner of each state promulgate prima facie acceptable rates at levels consistent with the 50% minimum loss ratio benchmark, taking into consideration such relevant statistics as are available.

INSURANCE COVERING INSTALLMENT SALES AND LOANS (H) COMMITTEE

(ref: 1960 Proc. Vol. I pp. 175-177; 180)

The Committee on Insurance Covering Installment Sales and Loans met in the West Ballroom of the Fontainebleau Hotel, Miami Beach, Florida, at 9:15 A.M. on December 2, 1959. Present were Commissioners J. Edwin Larson of Florida, Chairman; Charles F. Gold of North Carolina, Vice Chairman; Sam N. Berry of Colorado; Joseph S. Gerber of Illinois; C. P. Thurman of Kentucky; T. Nelson Parker of Virginia; Alexander H. Miller of Vermont; and Thomas Thacher of New York.

In the open session, Chairman Larson requested F. Roger Downey, Deputy Superintendent of the New York Department, to deliver the report of the (H1) Subcommittee — Insurance Problems in Connection with Installment Sales and Loans, a copy of which is attached. Director Joseph S. Gerber presented the report of the (H2) Subcommittee — Credit Life and Credit Accident and Health Model Bill Legislation, which is also attached. [In this Bulletin the Report of the (H1) Subcommittee is omitted.]

Mr. Edward Dunbar, of the Beneficial Finance Corporation made a statement in regard to benchmarks for the regulation of rates to be charged for credit life and credit accident and health insurance.

Mr. B. M. Anderson, of the Connecticut General Life Insurance Company urged the Committee to recommend benchmarks for the regulation of rates to be charged for these credit coverages.

Mr. William J. Walsh, of the Consumers' Credit Insurance Association, stated that consideration should be given by the Committee to the problems of all insurers concerned with these coverages.

Mr. John H. Binning, attorney of Lincoln, Nebraska, observed that special problems of insurers with lesser premium volume for credit coverages should be given consideration.

Mr. Charles F. J. Harrington, of the National Association of Casualty and Surety Agents, stated that the problem of regulation of credit insurance coverages had been a matter of consideration by the Committee for some time, and urged definitive recommendations.

In Executive Session, the reports of the H1 Subcommittee and H2 Subcommittee, referred to above, were unanimously adopted.

After discussion of the H2 Subcommittee report: Commissioner Berry moved adoption of the following resolution:

“The Committee in Executive Session recommends to all insurance supervisors that a rate for Credit Life or Credit Accident and Health, producing a loss ratio of under 50% should be considered to be excessive.”

This motion was duly seconded and unanimously adopted.

The Chairman then stated that all business before the Committee had been completed and that, as there were no additional matters to be presented to the Committee, he would entertain a motion to adjourn.

Such a motion was made and carried, and the meeting was adjourned at 11:00 A.M.

Respectfully submitted, Hon. J. Edwin Larson, Fla., Chm.; Hon. Charles F. Gold, N. C., V.Chm.; Hon. C. P. Thurman, Ky.; Hon. T. Nelson Parker, Va.; Hon. Alexander H. Miller, Vt.; Hon. Thomas Thacher, N. Y.; Hon. Sam N. Berry, Colo.; Hon. Joseph S. Gerber, Ill.

#### Credit Life and Credit A&H Model Bill Legislation (H2) Subcom. Report

(ref: 1960 Proc. Vol. I p. 180)

The Credit Life and Credit Accident and Health Model Bill Legislation Subcommittee was convened on Monday, November 30, 1959 at the Fontainebleau Hotel, Miami Beach, Florida. The Honorable Joseph S. Gerber, Chairman, presided. A quorum was present.

A proposed amended model bill to provide for the regulation of Credit Life Insurance and Credit Accident and Health Insurance was submitted. It was noted that the proposed amendments to the model bill should not be considered as urging or recommending changes in those states whose legislatures have heretofore enacted the model bill nor should it be taken to impose any question of legislative intent in the model bills as passed.

A discussion was had on the proposed changes and on motion duly made and seconded, it was resolved that the proposed changes be set over for further study.

The question of establishing a benchmark is also to receive the further study of this subcommittee.

Respectfully submitted, Hon. Joseph S. Gerber, Ill., Chm.; Hon. C. P. Thurman, Ky., V.Chm.; Hon. J. Edwin Larson, Fla.; Hon. William E. Grubbs, Neb.; Hon. Donald Knowlton, N. H.; Hon. T. Nelson Parker, Va.; Hon. Charles L. Manson, Wis.

## LIFE INSURANCE ASSOCIATION OF AMERICA

277 Park Avenue — New York, N. Y. 10017

Washington Office  
1701 K Street, Northwest  
Washington, D. C. 20006

February 21, 1968

Copy for: Honorable Louis T. Mastos

Sent to: Members of Life, Accident and Health Insurance Committee

Members of (E2) Subcommittee — Accident and Health Insurance

Chairman Mastos of the (E2) Subcommittee has invited us to submit a brief statement relative to that part of the Richmond Resolution dealing with the 50% loss ratio benchmark. We are happy to do so.

On June 20 of last year I sent you a copy of a Resolution adopted by the Board of Directors of this Association. That Resolution clearly sets forth our interpretation of what was intended by the Richmond Resolution. For ready reference a copy of the Resolution is enclosed. Our position has not changed.

I plan to attend the Las Vegas meeting and will be available to answer questions by NAIC members.

Sincerely,

Eldon Wallingford, Vice President  
State Government Relations

## Resolution Adopted by LIAA Board of Directors

May 19, 1967

- Resolved, That the Life Insurance Association of America reaffirms its support of the NAIC Model Bill to Provide for the Regulation of Credit Life and Credit Accident and Health Insurance and urges its adoption in all remaining states, and adopts the following policies regarding the regulation of credit life and credit health insurance rates in states where the commissioner has regulatory authority;
- I. That NAIC's recommended 50% ratio of incurred claims to earned premiums be supported as a minimum "benchmark" in applying state statutory requirements that credit insurance benefits be reasonable in relation to the premiums charged.
  - II. That support be given to the June, 1966, Resolution of the NAIC pursuant to which prima facie premium rates would be established and upward deviations from such prima facie premium rates could be obtained.
  - III. That in supporting the implementation of the June, 1966, Resolution of the NAIC, the staff be authorized to indicate to the appropriate state authorities that average national claim rate statistics of the 1964 NAIC Mortality Study indicate that a prima facie rate of 60¢ per \$100 per year for credit life insurance would be consistent with the 50% loss ratio "benchmark."
  - IV. That opposition be expressed to any proposed or promulgated prima facie credit life or credit health insurance premium rate in excess of that contemplated by the 50% loss ratio "benchmark" adopted by NAIC. This means that on the basis of the 1964 NAIC Mortality Study the Association would oppose any prima facie rate for credit life insurance in excess of 60¢ per \$100 per year.
  - V. That whenever a state regulatory body proposes to regulate credit insurance rates by promulgating a scale of prima facie rates which varies by total amount of insurance on all debtors of the creditor, the Association shall support the proposition in principle, provided the scale is based on rates similar to those promulgated in New York and New Jersey, or those currently proposed in California and Vermont.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA  
CORPORATE HOME OFFICE

Prudential Plaza Newark, N. J. 07101

ROBERT E. YOUNGER

Director, Government Relations  
External Affairs Department

February 19, 1968

To the Members of the NAIC Life, Accident and Health Insurance Committee and  
of the Credit Life and Credit Accident and Health Insurance Subcommittee

Gentlemen:

We welcome Commissioner Mastos' invitation to submit our views regarding a "definitive interpretation of that part of the Richmond Resolution dealing with the minimum loss ratio." Accordingly, a statement of our views is attached.

We will be happy to receive any comments or questions either prior to or at the Las Vegas meeting which we plan to attend.

Sincerely,

Robert E. Younger

MEMORANDUM OF THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

Re: Definitive Interpretation of the  
Richmond Resolution

This memorandum is respectfully submitted in accordance with Commissioner Mastos' invitation to the industry to submit written statements regarding the "definitive interpretation of that part of the Richmond Resolution dealing with the minimum loss ratio."

We believe it will contribute to an understanding of the Richmond Resolution to consider briefly its historical background.

In December of 1959, the NAIC adopted a resolution regarding the interpretation of the requirement of Section 7B of the Model Bill that premium rates for credit insurance be reasonable in relation to benefits. The resolution reads as follows:

"The Committee in Executive Session recommends to all insurance supervisors that a rate for Credit Life or Credit Accident and Health, producing a loss ratio of under 50% should be considered to be excessive."

While many states thereafter individually indicated their adherence to the 50% minimum loss ratio benchmark, only a mere handful adopted prima facie maximum rates which on the average would produce a 50% loss ratio and implementation of the benchmark on any basis other than the establishment of prima facie maximum rates was minimal if not non-existent. This resulted in many insurers achieving loss ratios of less than 50% as demonstrated by the findings of the NAIC 1964 Credit Life Mortality Study which showed that companies writing 56% of the Credit Life premium volume studied (Group plus Individual) produced loss ratios for their Credit Life insurance of less than 50%, averaging 38%, and that companies writing 85% of the Credit A & H premium volume studied (Group plus Individual) produced loss ratios for their Credit A & H insurance of less than 50%, averaging 32%. Under the circumstances, insurers, after paying claims and providing for their expenses and contingencies, in many cases had a very substantial portion of the premium left over. Pressure from creditors resulted in most of these sums being paid to the creditors in the form of commissions, dividends, retrospective rate credits, etc. The percentage of the premium being paid to the creditor approached and in many instances exceeded 50%. This led a few insurance departments to conclude that the percentage of the premium payable to the creditor should be limited.

The great majority of the industry felt that such limits treated only the symptom and ignored the disease — overcharging the public for credit insurance due to reverse competition. The industry felt that the way to treat the disease of overcharging was to limit the charge which may be made to the debtors and thus benefit debtors directly. Limiting the compensation paid the creditor by the insurer has no necessary effect on the charge to the debtor. It merely affects the split between the insurer and the

creditor and is not even effective in this area if the creditor owns the insurer or the reinsurer of the creditor's business. Consequently, the trade associations representing the writers of credit insurance prepared the draft resolution which ultimately was adopted by the NAIC at the Richmond meeting in June, 1966. (ref: 1966 Proc. Vol. II pp. 401-403; see pages 587-588).

The basic features of the Richmond Resolution are:

- (1) A rejection of the cap on compensation to the creditor;
- (2) Reaffirmation of support of the Model Bill;
- (3) Reaffirmation of the 50% loss ratio benchmark as a minimum;
- (4) An explicit outline of a recommended procedure for making the 50% minimum loss ratio effective by establishing prima facie maximum rates, coupled with reasonable deviation procedures, based on studies such as the NAIC 1964 Credit Life Insurance Mortality Study.

In any jurisdiction which adopts and enforces the Richmond Resolution according to its terms, the result, even assuming all insurers charge the maximum permissible rates, will be that in the aggregate at least one-half of the premium dollar will be returned to the debtor public in the form of claim payments. This result can be achieved without the burden on the insurance department of case-by-case supervision and without widely varying maximum rates for similar cases.

As we understand it, the precise question to be decided is whether the Richmond Resolution recommends the 50% loss ratio benchmark as a maximum or as a minimum. We are surprised that there could be any such question raised in view of the fact that the benchmark is repeatedly referred to in the Resolution (six times as shown on the attachment) as a minimum. The intention of the drafters of the Resolution could scarcely be more clear. It seems unreasonable to suggest that the NAIC could possibly have taken the position that anything less than 50% of the premium dollar should be paid out in claims or that rate standards should not be established which would return more than 50% of the premium in claims.

Our preference has been and is the promulgation of prima facie maximum rates based on the decremental scale principle as exemplified by the New York, New Jersey or Vermont regulation.

Despite our preference for the decremental scale, however, and in a spirit of compromise, we have supported the 50% loss ratio as a minimum. We have done so in the belief it represented a step in the right direction, and in the belief its adoption would not prevent a state from adopting prima facie maximum rates which would produce loss ratios higher than 50%. We understood the Richmond Resolution to mean minimum. But for that understanding, the Richmond Resolution would not have had our support nor the support of others. The clear intention was to establish a 50% floor under loss ratios, not a 50% ceiling over them.

In our judgment, it would be a crippling blow to the cause of state regulation if the NAIC were to take the position that no insurer may be required to return more than 50¢ of the credit insurance premium dollar to the debtor public as claims. Even as a minimum benchmark, the adoption of the 50% loss ratio may not avoid federal intervention in the regulation of the credit insurance business. During the recent round of hearings before the Senate Antitrust and Monopoly Subcommittee, Senator Hart described the 50% minimum loss ratio benchmark as "a very stumbling step" which makes an "unsatisfactory" situation out of what has been an "intolerable" situation.

In taking this position, we believe Senator Hart probably had in mind the fact that employee group insurance typically produces a loss ratio ranging from 70% to 85% or higher. Since credit insurance is mass marketed and usually involves little sales effort at the creditor-debtor level, a question naturally arises regarding the appropriateness of the 50% loss ratio.

Probably Senator Hart would have had a more favorable reaction to the 50% minimum loss ratio concept if the majority of the states had implemented the Richmond Resolution. Unhappily they have not done so. However, many states have moved in that direction. Three states have in effect a decremental scale of premium rates, which we believe is the preferred method of implementation. A number of other states have adopted flat prima facie rates, which do not vary by case size, with provision for upward rate deviations on specific cases.

In several states, the prima facie maximum credit life rate is set at 60¢ per \$100 for a 12-month loan, or lower. 60¢, of course, is the rate which is reached by doubling the average claim results shown by the 1964 NAIC Credit Insurance Study Except to

the extent affected by upward rate deviations, it can be expected to produce a loss ratio of at least 50%. Other states have adopted prima facie credit life rates which are higher. Undoubtedly, these states plan to adjust their prima facie rates downward after they have seen emerging experience for, perhaps, one or two years and can determine more specifically what prima facie maximum rate will produce a loss ratio of 50% or more. We certainly hope this is the case and that they are in no way blocked from doing so or from achieving a loss ratio above 50%.

In case it may be helpful to the Committee's deliberations, we are attaching a state-by-state summary which shows the status of regulation of Credit Life insurance rates now and as of December 31, 1966. We believe this attachment demonstrates the substantial progress in adopting effective regulations over the last year, but also shows clearly the need for the adoption of additional regulation. We sincerely believe this additional regulation is required promptly if federal intervention is to be avoided.

February 19, 1968



## Prima Facie Credit Life Insurance Rates\*

Adopted by Insurance Departments,

As of December 31, 1966 and February 19, 1968,

STATE	By State	
	1966	1968
Alabama	(A)	(A)
Alaska	—	—
Arizona	—	75¢
Arkansas	—	—
California	75¢	50% loss ratio (B)
Colorado	—	—
Connecticut	64¢	50¢
Delaware	—	—
District of Columbia	49¢ (C)	49¢ (C)
Florida	75¢ (indiv. only)	75¢ (indiv. only)
Georgia	—	—
Hawaii	—	—
Idaho	—	—
Illinois	75¢	65¢
Indiana	75¢	75¢
Iowa	—	—
Kansas	—	—
Kentucky	(A)	(A)
Louisiana	(A)	(A)
Maine	64¢	50¢
Maryland	—	—
Massachusetts	(A)	(E)
Michigan	60¢	60¢
Minnesota	—	75¢
Mississippi	(A)	(A)
Missouri	(A)	(A)
Montana	—	75¢
Nebraska	75¢	64¢
Nevada	75¢	75¢
New Hampshire	64¢	50¢
New Jersey	decremental	decremental
	44¢-64¢	44¢-64¢
New Mexico	75¢	65¢
New York	decremental	decremental
	44¢-64¢	44¢-64¢
North Carolina	—	—
North Dakota	—	—
Ohio	75¢	75¢
Oklahoma	—	—
Oregon	75¢ (C)	60¢
Pennsylvania	60¢ (Group)	60¢ (Group)
	75¢ (Indiv.)	75¢ (Indiv.)
Rhode Island	75¢	50¢ (D)
South Carolina	(A)	(A)
South Dakota	—	—
Tennessee	—	—
Texas	70¢-90¢	65¢-75¢
Utah	—	75¢
Vermont	—	decremental
	—	44¢-70¢
Virginia	—	—
Washington	—	60¢
West Virginia	—	—
Wisconsin	75¢ (C)	75¢ (C)
Wyoming	—	—

(A) Premium rate regulation provided for in laws regulating "small loans" lenders only.

(B) Statutory mandate which largely nullified adoption of decremental scale.

(C) Informal administrative ruling.

(D) Proposed.

(E) 50¢ maximum contribution applicable to most types of indebtedness.

\*Rates are per \$100 initial amount for a 12-month loan.

LIFE

HEALTH

## AMERICAN NATIONAL INSURANCE COMPANY

Home Office: Galveston, Texas

## CREDIT INSURANCE DIVISION

February 21, 1968

MEMORANDUM TO: Members of the NAIC (E) Committee  
and (E2) Subcommittee

RE: Interpretation of the 50% Loss Ratio Benchmark

During your forthcoming deliberations concerning the proper interpretation of the 50% loss ratio benchmark which had been recommended by the NAIC to the various states in order to establish a uniform method of determining whether the benefits provided are reasonable in relation to the premium charge pursuant to the authority set forth in Section 7 B of the NAIC Model Bill for credit life and credit accident and health insurance, we feel that it is very important to fully understand the circumstances surrounding the final adoption of the 50% loss ratio requirement by the NAIC.

As you may recall, Commissioner Joseph Gerber of Illinois was Chairman of a Subcommittee to determine the proper benchmark to be recommended by the NAIC to the various states in the administration of the "benefits" language set forth in the Model Bill and hearings were held in connection therewith at a meeting of the Subcommittee in French Lick and all segments of the industry were represented and given a full opportunity to present their views at said hearing. As you may further recall, a substantial segment of the industry, primarily composed of insurers specializing in the writing of credit life and credit accident and health insurance, urged that a 40% loss ratio be established as a benchmark and another segment of the industry, primarily composed of Eastern insurers, urged that a 60% loss ratio benchmark be established and recommended by the NAIC to the various states. After receiving rather exhaustive arguments from these and other segments of the industry, Chairman Gerber's Subcommittee adopted a 50% loss ratio benchmark which was later adopted by the following resolution of the NAIC during the 1959 Winter meeting in Florida:

"The committee in executive session recommends to all insurance supervisors that a rate for Credit Life or Credit Accident and Health, producing a loss ratio of under 50% should be considered to be excessive." (1960 Proc. Vol. I p. 176; see pages 588-589).

We should also like to indicate that all the discussions and arguments presented to the NAIC during its many deliberations on this matter made it perfectly clear that the 50% loss ratio benchmark was essentially a compromise between the 40% and 60% loss ratio benchmarks which were urged by various segments of the industry as indicated above and all segments of the industry were in agreement that the above-indicated 1959 resolution meant that any rate which produced a loss ratio of under 50% would be considered excessive and, conversely, any rate that produced a loss ratio of 50% would be considered reasonable. As a matter of fact, during the many hearings which have been held during the past several years to establish a proper prima facie acceptable rate in accordance with the 50% loss ratio requirement, the only real argument has been as to the proper level of prima facie acceptable rates and not as to the interpretation of the 50% loss ratio requirement.

Of course, since the adoption of the 50% loss ratio requirement by the NAIC, it has become common parlance to refer to said 50% loss ratio requirement as a minimum 50% loss ratio requirement, meaning, that any premium rate which does not produce a 50% loss ratio, would be considered excessive and subject to disapproval. As a matter of fact, the so-called Richmond resolution (ref: 1966 Proc. Vol. II pp. 401-403; see pages 587-588), specifically referred to and incorporated the prior action of the NAIC in adopting the so-called minimum 50% loss ratio benchmark and specific reference thereto is found in the various provisions thereof. It should be clearly understood, however, that the Richmond resolution was primarily directed to the enactment of the NAIC Model Bill and proper implementation of the 50% loss ratio benchmark and was not in any way meant to rescind or even modify the specific resolution which the NAIC adopted in 1959 in the establishment of the 50% loss ratio benchmark. As a matter of fact, the reference to a minimum 50% loss ratio requirement merely incorporated the most common and convenient terminology used by the industry in referring to the full text of the 1959 NAIC resolution covering this matter. It should also be noted that the last sentence of paragraph 4 of the Richmond resolution specifically states that "Insurers which produce loss ratios of less than 50% should be required to explain the reasons therefor," and thus, this clause further demonstrates a clear understanding that the 1966 Richmond resolution was not meant

in any way to rescind or modify the 1959 resolution of the NAIC specifically covering this point and that a loss ratio of 50% would be considered reasonable and not excessive within the intent of the so-called 50% minimum loss ratio requirement.

In view of the above, we find it very difficult to understand how anyone could reasonably argue that the so-called minimum 50% loss ratio requirement as established in the 1959 NAIC resolution and referred to in the 1966 NAIC resolution means that the NAIC recommended that the various states could set any loss ratio requirement as long as it was not less than 50%. As indicated above, the whole purpose of the 1959 NAIC resolution was to recommend a 50% loss ratio benchmark to the various states in order to establish uniformity in the interpretation of the "benefits" language set forth in Section 7 B of the NAIC Model Bill. Of course, we are all aware that any pronouncement by the NAIC is merely in the form of a recommendation and thus, we all recognize that, even though the NAIC recommended a 50% loss ratio benchmark to establish uniformity, any given Commissioner is not bound by such recommendation and would be entirely free to ignore the recommendations of the NAIC and adopt a higher or lower loss ratio requirement due to the particular situation in his own particular state. We also feel that, even after the adoption of the 50% loss ratio requirement by a particular state, the Commissioner would have inherent authority to exercise some discretion as to whether a particular rate should be cut or a deviation request should be approved. For example, a Commissioner may very well decide to exercise discretion if the loss ratio is within 5% of the 50% loss ratio benchmark. In other words, depending on various factors, the Commissioner may not automatically cut a company's rate if the loss ratio was at least 45% and the insurer demonstrated that loss ratios have been increasing each year and, similarly, the Commissioner may not approve a request for a deviation even though the loss ratio for a particular year was 55%.

We also feel that it is important for the NAIC to consider recommending uniform credibility standards so that the various Commissioners would, so far as possible, adopt the same credibility standards for purposes of rate approvals and disapprovals. In this regard, we feel that credibility standards requiring at least \$100,000 of earned premium and at least one year's experience but not to exceed three years would be quite realistic and would serve as a valuable aid to the various states in their efforts to effectively implement the 50% loss ratio requirement.

As the NAIC spent approximately two years in the formulation and adoption of the 50% loss ratio benchmark and as all segments of the industry were given adequate and full opportunity to present their respective viewpoints during that time and as all segments of the industry agreed with the 1959 resolution of the NAIC on this vital matter, we sincerely hope that your Committees will reaffirm the 1959 resolution and avoid any interpretation which would result in the NAIC recommending a loss ratio higher than 50% as any such interpretation would effectively preclude those insurers desiring to make a reasonable profit on this line of business from the marketplace and the business, particularly the larger cases, would gravitate to those insurers who are willing to write this business at such low premium rates that an underwriting profit could not reasonably be anticipated and an underwriting loss would be virtually assured.

We sincerely hope that you will consider our various views set forth in this memorandum and, as I plan to be in attendance at the forthcoming meeting of your Committees in Nevada, I shall be available and would be very pleased to answer any and all questions which you may have concerning our views on this very vital matter.

Yours cordially,

R. Roberts  
Counsel and Executive Assistant Manager

Accident and Health Insurance (E1) Subcom. Report  
(Mtg. 5)

The Accident and Health (E1) Subcommittee meeting in the Ballroom A in Portland, Oregon was held at 9 A.M. on June 17, 1968. A quorum was present and the following items were considered:

1. School Child Accident Insurance.

A memorandum was submitted by the Joint Industry Subcommittee which is attached. The memorandum was received by the Subcommittee and the Joint Subcommittee was discharged.

2. Accident and Health Insurance with Cash Surrender or other Non-Forfeiture Value.

It was reported that no meeting of the Subcommittee or the Industry Advisory Committee had been held; however, it was requested that such a meeting be held and a report submitted at the December meeting.

3. Need For Uniformity of Proof of Loss Forms in Connection with Cancelled Policies.

It was reported that the Mississippi Insurance Department had requested a study be made in regard to the manner in which medical diagnosis of cancer is required under such policies. It was suggested a Subcommittee be appointed to review this problem and a report be made at the December meeting. It was also requested that the HIAA submit whatever research material they may have in regard to this question to this Subcommittee.

The HIAA, through Mr. Peel, volunteered to submit periodic reports to the Subcommittee outlining areas of research and study which are being conducted relating to Health Insurance. The Subcommittee accepted this suggestion and requested that the HIAA make such reports.

No other matters were brought before the Subcommittee for action and the meeting was adjourned.

Hon. Dudley A. Guglielmo, Chm., La.; Hon. Durwood Manford, V.Chm., Tex.; Hon. Jerry P. Shea, Ariz.; Hon. Joseph G. Wood, Ind.; Hon. Robert D. Preston, Ky.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Charles R. Howell, N. J.; Hon. Edwin S. Lanier, N. C.; Hon. Joe B. Hunt, Okla.; Hon. James R. Faulstich, Ore.; Hon. Robert D. Haase, Wis.

## Memorandum

TO: Honorable Dudley Guglielmo, Chairman

Accident and Health Insurance Subcommittee

NAIC Joint Industry Committee to Study School Accident Insurance

The industry members of this Joint Committee submitted an interim report at the June, 1967, meeting in Boston. The industry Committee members have given further consideration to the interim report and have no additional recommendations to make at this time and, therefore, recommend that the interim report be adopted as the final report and that the Joint Committee be discharged.

Respectfully submitted, A. M. Hansen, Chm.; Lawrence G. Becker; John T. Manning;  
James F. Nagle.

June 17, 1968

## Credit Life and Credit Accident and Health Insurance

## (E2) Subcom. Report (Mtg. 28)

The Meeting of the (E2) Subcommittee — Credit Life and Credit Accident Insurance was called to order by Chairman Louis T. Mastos, at 4:00 p.m., in Ballroom A, Portland Hilton Hotel, June 17, 1968.

Chairman declared a quorum present.

The Credit Life and Credit Accident and Health Insurance (E2) Subcommittee Report of the Meeting of February 26 and 27th, 1968, at Las Vegas, Nevada (ref: see pages 573-598) was discussed as to whether or not any action of this Committee was needed, and action thereon deferred to the Executive Session of this Subcommittee.

The report of the meeting on June 16 of Subcommittee (E2a) To Study Mortality and Morbidity Experience of Credit Life and Health Insurance was read by Chairman Mastos. The Chairman asked whether any person present desired to discuss the report. In the absence of any comment, the Chairman indicated action on the report would be deferred to the Executive Session of this Subcommittee.

The Industry Advisory Committee Report is included in the (E2a) report and therefore no action on that item is necessary.

The NAIC Reporting Forms were referred to, and action thereon deferred to the Executive Session.

Mr. Jerry Sullivan of the Washington State Insurance Department presented a report compiled by the State of Washington on all direct Credit Life Insurance Business during the Calendar Year 1967, and action was deferred thereon to Executive Session of the Subcommittee. A status report on the proposed Uniform Consumer Credit Code was presented by Commissioner Barnes and it was received and made part of the record and is attached.

The Subcommittee then went into Executive Session and the following action was taken: No action was deemed necessary on the Credit Life & Credit Accident Insurance (E2) Subcommittee Report of Las Vegas, Nevada as it was deemed that all formal action had been taken on said report, and it is in the hands of the (E) Committee for any further action thereon. The Mortality and Morbidity Experience of Credit Life and Credit Accident and Health Insurance (E2a) Subcommittee Report of Meeting 1 on June 16 was received and approved by the (E2) Subcommittee, which will also include the Industry Advisory Committee Report. The Report on Direct Credit Life Insurance Business, in the

State of Washington, during the Calendar Year 1967, was received and is made part of the record and is attached.

The premiums and loss information compiled by the State of Nebraska by recent questionnaire to all State Insurance Departments was received in accordance with the instructions of the members of the Subcommittee, to be referred to President Bentley and/or his successor, for informational purposes in reply to Senator Hart's inquiry of this Association, on loss experience of Credit Insurance.

Commissioner Dykhouse discussed the status of the NAIC Credit Accident and Health Reporting Form, referred to on Page 390, Volume II, 1967 Proceedings of the Life Accident and Health Insurance (E) Committee Report. Upon due discussion thereon, the Subcommittee concluded that it should request the (E) Committee to return to this (E2) Subcommittee the responsibility for further study of the Credit Accident and Health Reporting Form.

There being no further business before this Subcommittee, the Meeting was adjourned at 5:00 p.m.

Hon. Louis T. Mastos, Chm., Nev.; Hon. Robert A. Short, V.Chm., Dela.; Hon. Walter S. Houseal, Ala.; Hon. J. Richard Barnes, Colo.; Hon. Broward Williams, Fla.; Hon. Lorne R. Worthington, Iowa; Hon. David J. Dykhouse, Mich.; Hon. Robert D. Scharz, Mo.; Hon. Charles R. Howell, N. J. by W. Harold Bittel; Hon. James R. Faulstich, Ore.; Hon. Chas. W. Gambrell, S. C.; Hon. James H. Hunt, Vt.; Hon. Frank R. Montgomery, W. Va.

Note: NAIC Model Credit Life and Credit A & H Bill (ref: 1961 Proc. Vol. I pp. 300-305; see pages 508-512).

## Uniform Consumer Credit Code

A special committee of the National Conference of Commissioners on Uniform State Laws has been working for several years on a proposed Uniform Consumer Credit Code. The first working draft was submitted to the National Conference at its 1966 annual meeting. Since that time there have been several further drafts, public hearings, and conferences with interested parties as well as advisory committees and panels of advisors on the subject.

Working Draft No. 8, which is the tentative final draft, has been made available and is published as Installment Credit Guide Extra Edition No. 176, May 13, 1968, by Commerce Clearing House, Inc. After modifications in Working Draft No. 8 needed to be made in order to make it conform to the requirements of the Federal Truth in Lending Bill, PL 90-321, signed into law on May 29, 1968, it will be submitted as a tentative final draft to the National Conference of Commissioners on Uniform State Laws at its 1968 annual meeting, July 22 through August 1, 1968 at Philadelphia, Pennsylvania. It is hoped that it will receive final approval at that time in order that it may be submitted to the legislatures of the various states in 1969. All interested parties are encouraged particularly to read the prefatory note which goes from page xiv through xxi.

Originally representing the National Association of Insurance Commissioners on the Panel of Advisors on Credit and Related Insurance was Frank Barrett, formerly President of the NAIC. Since June 1967, it has been J. Richard Barnes, Colorado Commissioner of Insurance.

The proposed Uniform Consumer Credit Code simplifies, clarifies, and modernizes laws governing installment sales, consumer credit, small loans and usury. It is a comprehensive statute designed to regulate most of the aspects of consumer credit, maximum consumer credit charges, and interest rates in general. It would relate to sales credit pertaining to the sale of goods or services to consumers, consumer loan credit, some credit pertaining to the sale and financing of homes, and some agricultural credit.

Exempted from the proposed Code are: financing of premiums in connection with the sale of insurance by insurers; carrier or utility rates regulated by the State or Federal Governments; and licensed pawn broker transactions.

Article 4 of the proposed Code pertains to insurance. Included therein are such matters as definitions, provisions for and relating to charges for insurance by creditors, excess charges to debtors, unconscionability resulting from all pertinent facts of a transaction involving credit insurance, maximum charges for insurance, refunds or credits, using of existing insurance, permitted choice of insurer, term of insurance, amount of insurance, and results from cancellation of insurance. The foregoing apply as appropriate to Life, A&H, and Property Insurance.

The proposed Code actually includes most of the salient important regulatory provisions of the NAIC Model Bill (ref: 1961 Proc. Vol. I pp. 300-305, see pages 508-512) for the Regulation of Credit Life and Credit Accident and Health Insurance. All of the foregoing items presume that the NAIC Model Credit Insurance Code has been enacted by each State, or will be passed when the Uniform Consumer Credit Code is also enacted in each State. This is clear from a reading of the numerous footnotes in the proposed Code which state that if the enacting State has not already enacted the NAIC Model Act for the Regulation of Credit Life and Credit Accident and Health Insurance, or similar legislation, that the material in brackets should be deleted before the proposed Uniform Consumer Credit Code is enacted. Section 4.203 of the proposed Code provides to the Insurance Commissioner authority to disapprove forms and rates in the absence of regulatory authority in that regard under other existing insurance law in the State.

## Property Insurance

While initial drafts of the Uniform Consumer Credit Code made reference only to Credit Life and A&H, the tentative final draft includes reference to property insurance. It prohibits a separate charge for loss of or damage to property unless the insurance covers a substantial risk of loss of or damage to property involved in the specific credit transaction. Amounts, term, and conditions of the insurance must be reasonable in relation to the transaction. Only where the amount financed and value of the property both exceed \$300 may insurance be included. Vendors single interest coverage is limited as is liability insurance. Specific limitations are placed on cancellation of property insurance.

A great deal of work and effort has gone into all phases of the Uniform Code, including the insurance phase. I strongly urge all Commissioners to become acquainted with the



Uniform Consumer Credit Code, to encourage its passage in their State. If the Model Credit Insurance bill is not already in your state law, I also urge that you get it enacted.

J. Richard Barnes, C.L.U.  
Commissioner of Insurance  
State of Colorado

Section I

All Direct Credit Life Insurance Business in the State of Washington  
During the Calendar Year 1967

A. Premium and Loss Information.

1. Premium and Losses — page 46, line 26 — Individual Insurance.

	Number of Companies	Direct Premiums Earned Col. 2	Direct Losses Incurred Col. 5
Domestic Companies	3	\$ 12,823	\$ 9,250
All Other Companies	19	262,688	77,503
<b>Totals</b>	<b>22</b>	<b>\$ 275,511</b>	<b>\$ 86,753</b>

2. Premium and Losses — page 46, line 27 — Group Insurance

	Number of Companies	Direct Premiums Earned Col. 2	Direct Losses Incurred Col. 5
Domestic Companies	5	\$2,157,203	\$1,109,945
All Other Companies	58	5,090,588	3,036,272
<b>Totals</b>	<b>63</b>	<b>\$7,247,791</b>	<b>\$4,146,217</b>

3. Total Credit Life Insurance In Force — Footnotes below Policy Exhibit Page 46.  
(Tabulate and Record to the Nearest 1000's)

	Previous Year	Current Year
Individual	\$ 8,557,006	\$ 13,105,681
Group	647,342,748	664,463,286

B. Regulatory Information.

SEE NOTES

1. Maximum Prima Facie Acceptable Credit Life Insurance Rate per \$100 of initial amount per year (decreasing)	\$ .60	1
2. Maximum Credit Life Insurance Rate per \$100 per year (level)	\$1.20	1
3. Minimum Loss Ratio Requirement	50%	1 & 2
4. Compensation Limitation	40% Max. Return To Creditor	1, 2 & 3

NOTES: 1. If none, leave blank.  
2. If you wish, explain how applied and enforced.  
3. Indicate forms of compensation so limited (i.e., all forms, commission only, commission and dividends, etc.)

Credit Life and A&H, 1965, 1966, and 1967  
Foreign Companies — Washington Business  
(1967 Premiums More Than \$25,000)

	Year	Life			Loss Ratio	A&H		Loss Ratio
		Premiums Earned	Divi- dend	Losses Incurred		Premiums Earned	Losses Incurred	
Aetna Life	1965	\$ 19,272		\$ 12,031				
	1966	21,064		37,060				
	1967	44,247		18,994				
	Totals	\$ 84,583		\$ 68,085	80%			
American Guaranty	1965	\$ 41,849		\$ 14,678		\$ 39,998	\$ 17,013	
	1966	65,237		11,545		65,564	35,710	
	1967	100,770		28,873		117,603	50,975	
	Totals	\$ 207,856		\$ 55,096	26	\$ 223,165	\$ 103,698	46%
American H & L	1965	\$ 69,610		\$ 23,488		\$ 91,158	\$ 29,675	
	1966	57,674		18,685		25,530	11,133	
	1967	67,456		33,796		25,612	12,817	
	Totals	\$ 194,740		\$ 75,969	39	\$ 143,300	\$ 53,625	37
American National	1965	\$ 9,555		\$ 2,187				
	1966	10,009		570				
	1967	34,652		19,439				
	Totals	\$ 54,216		\$ 22,196	41			
Bankers National	1965	\$ 58,138	\$ 82	\$ 37,040				
	1966	69,007	441	49,315				
	1967	69,016	2,062	48,670				
	Totals	\$ 196,161	\$ 2,585	\$ 135,025	69			
Charter National	1965	\$ 5,598		\$ 6,834				
	1966	32,865		14,557				
	1967	42,996		26,317				
	Totals	\$ 81,459		\$ 47,708	58			
Conn. General	1965	\$ 82,269		\$ 50,240		\$ 7,190	\$ 5,168	
	1966	56,420		37,429		24,387	8,141	
	1967	73,184		42,058		30,335	12,454	
	Totals	\$ 211,873		\$ 129,726	61	\$ 61,912	\$ 25,763	42
Continental Assur.	1965	\$ 214,740		\$ 64,331		\$ 0	\$ 4,545	
	1966	30,490		79,982		90,222	19,261	
	1967	141,266		99,120		88,230	76,008	
	Totals	\$ 386,496		\$ 243,433	63	\$ 178,452	\$ 99,814	56
Credit Life	1965	\$ 78,881		\$ 42,670				
	1966	77,628		36,767				
	1967	60,051		23,164				
	Totals	\$ 216,560		\$ 102,601	47			
Cuna Mutual	1965	\$ 863,627	\$102,477	\$ 601,458				
	1966	951,542	119,310	775,785				
	1967	1,041,862	133,757	810,629				
	Totals	\$2,857,031	\$360,544	\$2,187,872	76			
Heritage Life	1965	\$ 0		\$ 0				
	1966	7,293		0				
	1967	97,844		10,193				
	Totals	\$ 105,137		\$ 10,193	10			
Metropolitan Life	1965	\$ 55,640	\$ 4,832	\$ 35,408				
	1966	54,818	16,881	43,531				
	1967	51,409	2,881	37,937				
	Totals	\$ 161,867	\$ 24,594	\$ 116,876	72			

	Year	Life			Loss Ratio	A&H		Loss Ratio
		Premiums Earned	Dividend	Losses Incurred		Premiums Earned	Losses Incurred	
New York Life	1965	\$ 11,343		\$ 8,959				
	1966	72,625		80,984				
	1967	150,854		82,331				
	Totals	\$ 234,822		\$ 172,274	73%			
North American L&C	1965	\$ 0		\$ 0				
	1966	6,057		10,942				
	1967	26,362		0				
	Totals	\$ 32,419		\$ 10,942	34			
Occidental Life (California)	1965	\$ 26,684		\$ 20,271				
	1966	62,311		87,292				
	1967	48,914		58,554				
	Totals	\$ 137,909		\$ 166,117	120			
Old Republic Life	1965	\$ 373,018		\$ 151,348				
	1966	373,188		226,504				
	1967	472,916		231,903				
	Totals	\$1,219,122		\$ 609,755	50			
Pacific Fidelity	1965	\$ 159,030		\$ 50,445		\$ 37,199	\$ 14,402	
	1966	85,313		35,549		58,555	28,589	
	1967	75,128		49,784		98,221	39,762	
	Totals	\$ 319,471		\$ 135,778	42	\$ 193,975	\$ 82,753	43%
Pacific Standard	1965	\$ 882,418		\$ 341,383				
	1966	1,146,298		476,715				
	1967	1,359,800		560,632				
	Totals	\$3,388,516		\$1,378,730	41			
Prudential	1965	\$1,018,475	\$135,718	\$ 767,499		\$ 98,374	\$ 98,556	
	1966	991,046	177,631	814,996		111,293	124,319	
	1967	1,007,164	169,412	647,445		114,013	107,344	
	Totals	\$3,017,238	\$482,811	\$2,229,940	74	\$ 323,680	\$ 330,219	102
Resolute Credit	1965	\$ 95,501		\$ 38,231				
	1966	84,358		52,303				
	1967	104,775		42,782				
	Totals	\$ 284,634		\$ 133,316	47			
Standard	1965	\$ 26,061		\$ 21,102				
	1966	30,834		21,082				
	1967	32,397		24,984				
	Totals	\$ 89,292		\$ 67,168	75			
Continental Casualty	1965					\$ 0	\$ 0	
	1966					568	997	
	1967					28,325	21,311	
	Totals					\$ 28,893	\$ 22,308	77
Transportation (Casualty)	1965					\$ 0	\$ 0	
	1966					82,491	7,169	
	1967					35,929	3,012	
	Totals					\$ 118,420	\$ 10,181	8
Grand Totals		\$13,481,492		\$8,098,800	60	\$1,271,797	\$ 723,361	57

Credit Life and A & H 1965, 1966, and 1967  
Domestic Companies — Washington Business

	Year	Life			Loss Ratio	A&H		Loss
		Premiums Earned	Dividend	Losses Incurred		Premiums Earned	Losses Incurred	
Northwestern Life	1965	\$ 342,033		\$ 162,406		\$ 50,495	\$ 21,482	
	1966	522,015		267,871		113,751	89,460	
	1967	1,090,077		486,346		218,554	101,416	
	Totals	\$ 1,954,125		\$ 916,623	47%	\$ 382,800	\$ 212,358	55%
Olympic National	1965	\$ 443,349		\$ 185,670		\$ 319,750	\$ 107,711	
	1966	486,931		180,733		309,425	145,573	
	1967	509,741		224,477		356,509	190,786	
	Totals	\$ 1,440,021		\$ 590,880	41	\$ 985,634	\$ 444,070	45
Rainier Life	1965	\$ 0		\$ 0				
	1966	18,500		6,304				
	1967	29,235		10,766				
	Totals	\$ 47,735		\$ 17,070	36			
Safeco Life	1965	\$ 112,698		\$ 72,184				
	1966	178,752		129,917				
	1967	268,095		197,966				
	Totals	\$ 559,545		\$ 400,067	71			
United Pacific	1965	\$ 229,540		\$ 193,455		\$ 86,331	\$ 49,717	
	1966	235,258		217,084		72,414	55,962	
	1967	271,910		195,670		63,931	61,102	
	Totals	\$ 736,708		\$ 606,209	82	\$ 222,676	\$ 166,781	75
Grand Totals		\$ 4,738,134		\$ 2,530,849	53	\$ 1,591,160	\$ 823,209	52
		13,481,492		8,093,800				
		\$18,219,626		\$10,629,649	58%			

**To Study Mortality and Morbidity Experience of Credit Life and  
Credit Accident and Health Insurance (E2a) Subcom. Report**

(Mtg. 1)

The Meeting of the (E2a) Subcommittee on Mortality and Morbidity Experience — Credit Life and Accident and Health Insurance was called to order by Chairman Mastos at 3:00 p.m. in Galleria #2, Portland Hilton Hotel, June 16, 1968. The Chairman declared a quorum present.

Chairman Mastos announced new appointments to the Industry Advisory Committee consisting of the following:

1. James A. Gobes, Actuary — Connecticut General Life Insurance Company — replacing William W. Keffer of the same Company.
2. Mr. William K. Poulson, Vice President and Actuary — Old Republic Life Insurance Company — replacing William Lewis of the American Bankers Life Assurance Company.

The Chairman then called upon Stanley W. Gingery, Vice President and Associate Actuary of Prudential Insurance Company who is Co-Chairman of the Industry Advisory Committee, for the report of said Advisory Committee. Mr. Gingery presented the April 26th Industry Advisory Committee Report and Supplement attached hereto. In addition Mr. Gingery presented material requested by Commissioner Hunt of Vermont as outlined in a letter dated June 10, and attached hereto.

After due discussion on the material presented, the Subcommittee went into Executive Session at 4:05 p.m. In the Meeting of the Executive Session, this Subcommittee heard the motion of Commissioner James Hunt of Vermont that this (E2a) Subcommittee recommend to the (E2) Subcommittee that the Industry Advisory Committee Report and Supplement thereto, together with attachments compiled by Mr. Gingery at Mr. Hunt's request, be received for inclusion in the record of these proceedings. This motion was seconded by Mr. Bittel, and after due discussion thereon was unanimously passed.

The Subcommittee then discussed the Recommended Instructions of the Industry Advisory Committee and Mr. Bittel moved that we adopt as follows: "I move that we adopt the recommendations of the Industry Advisory Committee which appears as Exhibit B of the report which was dated April 26, 1968, headed '1969 Study of Claim Experience under Credit Life Insurance.'" (see pages 619-621) This motion was seconded by Commissioner Hunt and passed unanimously.

The question then arose as to which company would be named as compiling company, and there being no volunteers during the regular session of this Subcommittee except for the Prudential Insurance Company of America, it was moved by Mr. Faircloth of Florida that we accept the acquiescence of the Prudential Insurance Company to be named as compiling company. This was seconded by Commissioner Hunt and passed unanimously.

The question then arose as to the method of financing costs of such a Report, and after due discussion Mr. Bittel moved as follows: "The expenses of the compiling company which should exclude the cost of the professional actuaries will be prorated among those companies which agree to contribute to the costs of compiling this study based on the sum of the 1968 and 1969 life insurance premiums as reported in Part I of the Credit Life and Accident and Health Experience Exhibit (direct plus assumed less ceded re-insurance) which is net of refunds on credit transactions which are terminated prior to their maturity date, but which should be before any reduction because of retrospective rating premium refunds or dividends." This motion was seconded by Mr. Faircloth and unanimously passed.

The Meeting adjourned at 5:15 p.m.

Hon. Louis T. Mastos, Chm., Nev.; Hon. Robert A. Short, V.Chm., Del.; Hon. Walter S. Houseal, Ala.; Hon. Broward Williams, Fla.; Hon. Robert D. Scharz, Mo.; Hon. Charles R. Howell, N. J.; Hon. James H. Hunt, Vt.

## EXHIBIT A

STANLEY W. GINGERY  
Vice President and Associate Actuary

THE PRUDENTIAL  
INSURANCE COMPANY OF AMERICA  
HOME OFFICE  
Prudential Plaza — Newark, N. J. 07101

April 26, 1968

Honorable Louis T. Mastos  
Insurance Commissioner  
Nevada Department of Commerce  
Insurance Division  
Carson City, Nevada 89701

Dear Commissioner Mastos:

In accordance with yesterday's telephone conversation, I am enclosing a copy of the Industry Advisory Committee's report in response to the Credit Life and Credit Accident and Health Insurance (E2) Subcommittee's request (ref: 1968 Proc. Vol. I pp. 143-145) at the December 1967 NAIC meeting in Hawaii. As I mentioned over the phone, it was possible for the Industry Advisory Committee to produce a consensus report. As I also mentioned, you will note that the figures concerning the number of companies volunteering to make assessments, the premium income of those companies, and the rate of assessment are in this report.

I am also sending copies of this report, in accordance with your request, to Messrs. Malcolm Moss, ALC; Joe O'Regan, HIAA; Albert Pike, LIAA; and Walter Runkle, CCIA; in order that the industry may be informed of the contents of this report prior to the Portland meeting. As I understand it, this will be taken up at the meeting of the Special Task Force to Study Mortality and Morbidity Experience of Credit Life and Credit Accident and Health Insurance (E2a) Subcommittee. The results of this Subcommittee's meeting, as I also understand, will be reported to the Credit Life and Credit Accident and Health Insurance (E2) Subcommittee in Portland.

It was a pleasure to talk with you yesterday, and I am looking forward to seeing you at the Portland meeting of the NAIC.

Sincerely,

Stanley W. Gingery

cc: Industry Advisory Committee Members

TO SPECIAL TASK FORCE TO STUDY MORTALITY AND  
MORBIDITY EXPERIENCE OF CREDIT LIFE AND CREDIT  
ACCIDENT AND HEALTH INSURANCE (E2a) SUBCOMMITTEE

The Industry Advisory Committee met at the offices of the HIAA in New York City on Wednesday, March 13, 1968. The following topics were discussed:

1. Compiling Expenses of the NAIC Credit A & H Study

In December, 1966 this Committee, in connection with its proposal of a study of Credit A & H experience, proposed a method by which the writers of this coverage could share the expenses of compiling the study. This was accepted by the NAIC Subcommittee and companies were solicited to commit themselves to share these expenses.

75 companies writing earned premiums during 1965 and 1966 of \$161,336,798 accepted this invitation. The compiling company's expenses for the study, chargeable in accordance with the proposal, totaled \$44,277.51. Thus, each company's share represents \$.02744415 per \$100 of earned premium for the 2-year period.

2. NAIC Credit A & H Study

In accordance with the request of the NAIC Subcommittee on Credit Life and Credit A & H insurance at their December, 1967 meeting, the Industry Advisory Committee agreed, by a vote of 6 to 2, that the results of the study could be

presented in a single Basic Table that could be used to determine consistent claim costs by plan of benefit, elimination period and duration of indebtedness.

To avoid, to the extent possible, the need for, and the influence on the results, of individual judgment, the construction of the Table was based on composite factors that depended only on the volume of data and the level of claim costs observed in the various subdivisions of the study.

The Committee wishes to point out that as can be expected from the nature of the credit insurance business from which the data for this table was constructed there were apparent inconsistencies in claim costs among the various plans as seen in Table VII of the December 4, 1967 Report of the Industry Advisory Committee (ref: 1968 Proc. Vol. I pp. 147-211) and an apparent range of considerable magnitude in claim costs as among the various companies contributing to the study as seen in Table IVa of that Report. The Basic Table therefore represents as nearly as possible a mechanical "averaging" of rather diverse underlying components.

The attached Exhibit A presents the Basic Table and a description of its derivation and use as a practical answer to this request.

### 3. 1969 Study of Credit Life Insurance

In December, 1967 the Industry Advisory Committee proposed a schedule of studies of experience under credit insurance. The first such study would cover experience under credit life insurance for the year 1969. This proposal was accepted by the NAIC Subcommittee at its December meeting in Honolulu. (ref: 1968 Proc. Vol. I pp. 143-145)

In accordance with this schedule and the suggestion that advance notice and specific instructions be made available to the contributing companies, the attached Exhibit B presents a proposed set of such instructions. These instructions follow the form of Part B of the 1964 study of credit life insurance with the following exceptions. Information concerning the effective date of insurance under each Experience Unit has not been requested. This information is not always available to the current insurance carrier and the results concerning this item in the earlier study were inconclusive. Information concerning type of indebtedness has not been requested. The earlier study showed that a large portion of the experience was under Experience Units whose type of indebtedness could not be classified because it consisted of mixed types or the information was not available.

#### Industry Advisory Committee:

Mr. Stanley W. Gingery, Vice President & Actuary — Prudential —  
Co-Chairman

Mr. LeRoy T. Watkins, Vice President & Actuary — Valley Forge Life Insurance  
Company Co-Chairman

Miss Josephine W. Beers, Assistant Actuary — Occidental Life Insurance Company

Mr. William E. Burns, Actuary — CUNA Mutual Insurance Society

Mr. William W. Keffer, Vice President — Connecticut General Life  
Insurance Company

Mr. William K. Nicol, Vice President & Actuary — American National  
Insurance Company

Mr. James L. Purdy, Actuary — The Travelers

Mr. Harold E. Ruck, Vice President & Actuary — The Volunteer State

#### Life Insurance Company

Mr. William H. Lewis, Vice President & Actuary — American Bankers  
Life Assurance Company, participated in the discussion of this report  
as a member of the Industry Advisory Committee, but resigned effective  
as of March 26, 1968.



## 1968 Basic Table of Credit A&amp;H Claim Costs

The objective of this Basic Table is to present the results of the NAIC Credit A & H study in the form of the cost of each day of disability, from which consistent claim costs for a variety of plans of benefit, elimination periods and durations of indebtedness can be determined.

This Basic Table was designed to preserve the overall level of experience observed in the study and to reflect the cost variation by amount shown by the study.

The Table was derived as follows:

1. A claim cost, based on the annual claim frequency and the persistency to that day of disability, was determined for each day of disability on the basis of the experience of each of the five plans included in the study.
2. The difference between costs under a retroactive plan and a non-retroactive plan of the same elimination period was recognized as a "malingering effect." The Basic Table is designed so that the malingering effect must be considered separately in its use for retroactive plans.
3. The claim costs for each day of disability as observed for the five plans were composited, weighting each plan's claim cost by its total experience contributed to the study.
4. Such composite claim costs were set at such a level as to reproduce, for broad periods of disability, the total days of disability observed in the study.
5. These graduated claim costs were then adjusted for the cost variation by amount observed in the study separately for the first 30 days of disability, covered by only the 7 and 14 day plans, and for the later days of disability covered by all plans.

The adjusted graduated claim costs constitute the Basic Table of Credit A & H claim costs. For each day of disability the following values are presented:

1.  $C_t^d$  -- The claim cost, on an annual basis, of a benefit of \$1.00 for day of disability  $t$ .
2.  $M_t^d$  -- The sum of the values of  $C_t^d$  from the earliest day of disability through day  $t$ .
3.  $R_t^d$  -- The sum of the values of  $M_t^d$  from the earliest day of disability through day  $t$ .

The following formulas apply in the use of this Basic Table:

${}^R_e C_n$  = single claim cost per \$100 initial amount of indebtedness, of n months or t days initial duration (where  $t=30n$ ), under a plan providing pro-rata, or per diem, benefits with an elimination or qualification period of e days, with benefits retroactive to the first day of disability.

${}^{NR}_e C_n$  = corresponding cost for a similar plan but with benefits non-retroactive.

$${}^R_e C_n = {}^A_e C_n + 1.15 {}^B_e C_n + {}^Q_e C_n$$

$${}^{NR}_e C_n = {}^A_e C_n$$

where

${}^A_e C_n$  = Installment benefit

$$= \frac{100}{360t} [R_t^d - R_e^d - (t-e) M_e^d]$$

${}^B_e C_n$  = Retroactive benefit

$$= \frac{100}{360t} [e(t-e) C_{e+1}^d]$$

${}^Q_e C_n$  = Malingering adjustment for installment benefit

$$= \frac{100}{360t} [.15(t-e) C_{e+1}^d + .14(t-e-1) C_{e+2}^d + .13(t-e-2) C_{e+3}^d + \dots + .01(t-e-14) C_{e+15}^d]$$

$.15 {}^B_e C_n$  = Malingering adjustment for retro benefit.

The claim costs which are shown in the following table resulted from the use of this Basic Table and these formulas.

SINGLE CLAIM COST PER \$100 INITIAL INDEBTEDNESS

Duration of Indebtedness (Months)	7 Retro	14 Retro	14 Non-Retro	30 Retro	30 Non-Retro
6	\$ .866	\$ .857	\$ .619	\$ .768	\$ .423
7	.936	.928	.688	.843	.488
8	.999	.992	.749	.909	.547
9	1.056	1.050	.805	.969	.601
10	1.108	1.102	.856	1.022	.650
11	1.156	1.150	.903	1.072	.695
12	1.200	1.195	.947	1.117	.738
13	1.241	1.236	.987	1.160	.778
14	1.280	1.275	1.026	1.200	.815
15	1.316	1.312	1.062	1.237	.851
16	1.351	1.347	1.096	1.273	.884
17	1.384	1.380	1.129	1.306	.917
18	1.416	1.412	1.160	1.338	.947
19	1.446	1.442	1.190	1.369	.977
20	1.475	1.472	1.219	1.399	1.006
21	1.503	1.500	1.247	1.427	1.033
22	1.531	1.527	1.274	1.455	1.060
23	1.557	1.554	1.301	1.482	1.086
24	1.583	1.579	1.326	1.508	1.111
25	1.608	1.604	1.351	1.533	1.136
26	1.632	1.629	1.375	1.558	1.160
27	1.656	1.653	1.399	1.582	1.183
28	1.679	1.676	1.422	1.605	1.206
29	1.702	1.699	1.445	1.628	1.229
30	1.724	1.721	1.467	1.651	1.251
31	1.746	1.743	1.489	1.673	1.272
32	1.767	1.765	1.510	1.694	1.293
33	1.788	1.786	1.531	1.716	1.314
34	1.809	1.806	1.552	1.737	1.335
35	1.829	1.827	1.572	1.754	1.355
36	1.849	1.847	1.592	1.777	1.375
37	1.869	1.867	1.612	1.797	1.394
38	1.888	1.886	1.631	1.816	1.413
39	1.908	1.905	1.650	1.836	1.432
40	1.926	1.924	1.669	1.855	1.451
41	1.945	1.943	1.687	1.873	1.470
42	1.963	1.961	1.706	1.892	1.488
43	1.981	1.979	1.724	1.910	1.506
44	1.999	1.997	1.741	1.928	1.523
45	2.017	2.015	1.759	1.946	1.541
46	2.034	2.032	1.776	1.963	1.558
47	2.052	2.049	1.794	1.981	1.575
48	2.069	2.066	1.811	1.998	1.592
49	2.085	2.083	1.827	2.015	1.609
50	2.102	2.100	1.844	2.031	1.626
51	2.118	2.116	1.860	2.048	1.642
52	2.135	2.133	1.877	2.064	1.658
53	2.151	2.149	1.893	2.080	1.674
54	2.167	2.165	1.909	2.097	1.690
55	2.183	2.181	1.925	2.112	1.706
56	2.198	2.196	1.940	2.127	1.721
57	2.214	2.212	1.956	2.144	1.737
58	2.229	2.227	1.971	2.159	1.752
59	2.245	2.243	1.987	2.175	1.768
60	2.260	2.258	2.002	2.190	1.783

Prepared April, 1968

## 1968 BASIC TABLE OF CREDIT A &amp; H CLAIM COSTS

Day of Disa- bility	End of Month	d C t	d M t	d R t	Day of Disa- bility	End of Month	d C t	d M t	d R t
					46		.0833	1.7711	37.3874
8		.0586	.0586	.0586	47		328	1.8039	39.1913
9		580	.1166	.1752	48		324	1.8363	41.0276
10		573	.1739	.3491	49		320	1.8683	42.8959
11		565	.2304	.5795	50		316	1.8999	44.7958
12		557	.2861	.8656	51		313	1.9312	46.7270
13		550	.3411	1.2067	52		309	1.9621	48.6891
14		544	.3955	1.6022	53		305	1.9926	50.6817
15		539	.4494	2.0516	54		301	2.0227	52.7044
16		535	.5029	2.5545	55		297	2.0524	54.7568
17		532	.5561	3.1106	56		294	2.0818	56.8386
18		529	.6090	3.7196	57		290	2.1108	58.9494
19		525	.6615	4.3811	58		286	2.1394	61.0888
20		521	.7136	5.0947	59		282	2.1676	63.2564
21		516	.7652	5.8599	60	2	279	2.1955	65.4519
22		510	.8162	6.6761					
23		503	.8665	7.5426	61		275	2.2230	67.6749
24		496	.9161	8.4587	62		271	2.2501	69.9250
25		488	.9649	9.4236	63		268	2.2769	72.2019
26		479	1.0128	10.4364	64		264	2.3033	74.5052
27		469	1.0597	11.4961	65		261	2.3294	76.8346
28		458	1.1055	12.6016	66		258	2.3552	79.1898
29		446	1.1501	13.7517	67		255	2.3807	81.5705
30	1	433	1.1934	14.9451	68		252	2.4059	83.9704
					69		249	2.4308	86.4072
31		419	1.2353	16.1804	70		246	2.4554	88.8626
32		405	1.2758	17.4562	71		244	2.4798	91.3424
33		392	1.3150	18.7712	72		241	2.5039	93.8463
34		381	1.3531	20.1243	73		238	2.5277	96.3740
35		372	1.3903	21.5146	74		235	2.5512	98.9252
36		365	1.4268	22.9414	75		233	2.5745	101.4997
37		359	1.4627	24.4041	76		231	2.5976	104.0973
38		354	1.4981	25.9022	77		228	2.6204	106.7177
39		350	1.5331	27.4353	78		226	2.6430	109.3607
40		347	1.5678	29.0031	79		224	2.6654	112.0261
41		344	1.6022	30.6053	80		221	2.6875	114.7136
42		342	1.6364	32.2417	81		219	2.7094	117.4230
43		340	1.6704	33.9121	82		217	2.7311	120.1541
44		338	1.7042	35.6163	83		215	2.7526	122.9067
45		336	1.7378	37.3541	84		213	2.7739	125.6806
					85		211	2.7950	128.4756
					86		209	2.8159	131.2915
					87		207	2.8366	134.1281
					88		204	2.8570	136.9851
					89		202	2.8772	139.8623
					90	3	200	2.8972	142.7595

1968 BASIC TABLE OF CREDIT A & H CLAIM COSTS

Day of Disability	End of Month	d C <sub>t</sub>	d M <sub>t</sub>	d R <sub>t</sub>	Day of Disability	End of Month	d C <sub>t</sub>	d M <sub>t</sub>	d R <sub>t</sub>
90	3	.0200	2.8972	142.7595	930	31	.00367	8.1599	5,348.1960
120	4	156	3.4181	238.0641	960	32	361	8.2692	5,594.6909
150	5	129	3.8393	347.3221	990	33	356	8.3768	5,844.4375
180	6	111	4.1971	468.1776	1020	34	351	8.4827	6,097.3861
210	7	.00958	4.5023	598.9178	1050	35	345	8.5871	6,353.4889
240	8	854	4.7726	738.2504	1080	36	341	8.6900	6,612.7001
270	9	763	5.0135	885.2288	1110	37	336	8.7915	6,874.9756
300	10	701	5.2323	1,039.0637	1140	38	332	8.8916	7,140.2747
330	11	652	5.4343	1,199.2010	1170	39	328	8.9905	7,408.5584
360	12	607	5.6225	1,365.1799	1200	40	324	9.0882	7,679.7902
390	13	565	5.7973	1,536.5905	1230	41	320	9.1847	7,953.9350
420	14	536	5.9619	1,713.0818	1260	42	317	9.2802	8,230.9595
450	15	514	6.1194	1,894.3952	1290	43	313	9.3747	8,510.8331
480	16	495	6.2707	2,080.3363	1320	44	310	9.4682	8,793.5248
510	17	481	6.4168	2,270.7318	1350	45	307	9.5607	9,079.0066
540	18	467	6.5588	2,465.4454	1380	46	304	9.6524	9,367.2508
570	19	452	6.6960	2,664.3443	1410	47	301	9.7431	9,658.2300
600	20	443	6.8304	2,867.3142	1440	48	298	9.8330	9,951.9189
630	21	435	6.9620	3,074.2723	1470	49	295	9.9221	10,248.2924
660	22	427	7.0912	3,285.1418	1500	50	293	10.0104	10,547.3259
690	23	419	7.2181	3,499.8512	1530	51	290	10.0979	10,848.9956
720	24	412	7.3429	3,718.3336	1560	52	288	10.1847	11,153.2791
750	25	405	7.4655	3,940.5256	1590	53	286	10.2707	11,460.1538
780	26	399	7.5861	4,166.3653	1620	54	283	10.3560	11,769.5984
810	27	392	7.7047	4,395.7920	1650	55	281	10.4406	12,081.5916
840	28	386	7.8213	4,628.7461	1680	56	278	10.5246	12,391.5456
870	29	379	7.9361	4,865.1692	1710	57	277	10.6079	12,713.1434
900	30	373	8.0489	5,105.0043	1740	58	275	10.6906	13,032.6631
					1770	59	273	10.7726	13,354.6532
					1800	60	271	10.8541	13,679.0956

EXHIBIT B

1969 STUDY OF CLAIM EXPERIENCE UNDER CREDIT LIFE INSURANCE

For this study "Credit Life Insurance" is defined as that form of insurance under which the life of the borrower of money or purchaser of goods is insured in connection with a specific loan or credit transaction. Lump sum benefits in the event of the total and permanent disability of the debtor may be included in the coverage. Credit A & H insurance may be provided in conjunction with the credit life insurance, but the experience under this coverage will not be included in this study. This definition of credit life insurance shall not include insurance in connection with loans of more than 60 months duration.

The study is intended to cover credit life insurance provided under group policies and "decreasing amount" credit life insurance provided under individual policies. Life insurance under individual policies which covers an indebtedness of a level amount may be included.

The study is intended to cover experience of U. S. business. The eligibility of an Experience Unit may be based on the currency involved in the policy. However, an Experience Unit may be included if more than 90% of the covered indebtedness was transacted within the U. S.

Data for this study should be submitted punched into blank IBM card stock. The contributing company will punch and verify the cards and run the prescribed list and totals and check for reasonableness before submission. Each card should be interpreted showing Company Code and Experience Unit number.

Data will be collected by Experience Unit. Generally the term "Experience Unit" is defined as the plan of insurance protection covering the debtors of a creditor-policyholder in the case of Group insurance or of a creditor in the case of Individual-policy insurance. However, the definition of "Experience Unit" may be modified, depending on the form of information available from the records of the contributing company. If necessary, an Experience Unit may include the experience under the insurance covering more than one creditor. If the insurance of one creditor covers two or more types of indebtedness, and if separate records are available for each type, these should be reported separately as two or more Experience Units. When so modified, this should be appropriately coded in column 10. Note that all of the life insurance coverage under an Experience Unit must provide the same type of benefit, as coded in column 16; for example a case under which some of the debtors are covered for life insurance only and others for life and lump sum disability insurance must be split and reported as two Experience Units, one for each such combination of benefits. An Experience Unit will include experience under all of the certificates or individual policies within the Unit.

Experience under each Experience Unit will be collected for the year 1969, or for any part of 1969 for which the Unit was in force. As convenient to the contributing company, experience may be reported on a policy year or a calendar year basis; i.e., experience during policy years ending in 1969 or experience during calendar year 1969.

One card should be used for each "Experience Unit."

Experience under an Experience Unit whose exposure is less than \$50,000 need not be included because of the small volume these Units will contribute to the study.

Experience under any installment disability benefit insurance will not enter or affect this study.

Each contributing company should submit, together with the cards, a complete listing and control totals showing:

- |                    |               |
|--------------------|---------------|
| 1. Card Count      |               |
| 2. Exposure        | Columns 17-23 |
| 3. Incurred Losses |               |
| a. Death           | 24-31         |
| b. Disability      | 32-37         |
| c. Other           | 38-43         |

Specific instructions for completion of the card are as follows:

Columns 1-3

Company Code

Use assigned code as company identification.

Column 4	<p>Year of Experience</p> <p>Code 1 Policy year, ending in 1969 2 Calendar year, 1969</p> <p>In addition, enter an X overpunch in column 4 for a "closed loan" case (under which during the year no new loans were covered).</p>
Columns 5-10	<p>Experience Unit Identification (number or code)</p> <p>If the Experience Unit covers the insurance of more than one creditor or less than all of the insurance of one creditor (as allowed above in the definition of "Experience Unit"), enter an X overpunch in Column 10.</p>
Column 11	<p>Policy Form</p> <p>Code 1 Group policy 2 Individual policies 3 Combination</p>
Column 12	<p>Type of Creditor</p> <p>Code 1 Bank (commercial or savings) 2 Sales finance company, automobile 3 Sales finance company, other consumer goods 4 Dealer, retail vendor 5 Small loan company, consumer finance company 6 Credit Union (borrowers only) 7 Production Credit Association, Federal Land Bank, etc. 8 All others</p>
Column 13	<p>Premium Payment</p> <p>Code 1 Single premium method, where the full premium is turned over immediately by the creditor to the insurance company.</p> <p>2 Outstanding balance method, where each month's premium payment by the policyholder depends on the amount of insured outstanding indebtedness covered during the month.</p>
Column 14	<p>Insurance Option</p> <p>Code 1 Insurance coverage required with loan 2 Insurance optional</p>
Column 15	<p>Maximum Amount</p> <p>Enter 1 in this column if the maximum amount of insurance on any one life within the Experience Unit may exceed \$15,000. Otherwise enter 2.</p>
Column 16	<p>Type of Benefit</p> <p>Code 1 Death benefits only</p> <p>Death and lump sum total and permanent disability benefits.</p> <p>Code 2 True T &amp; P coverage (medically established), with benefits determined as of the date of disability.</p> <p>3 180 days (or six months) waiting period, with benefits determined as of the date of disability.</p> <p>4 180 days (or six months) waiting period, with benefits determined as of the end of the waiting period.</p> <p>5 Other</p>

Columns 17-23	<p><b>Exposure, in thousands of dollars</b></p> <p>The exposure should be based on actual amount of insured remaining indebtedness, rather than on initial amount of loan. It may be calculated by averaging amounts of insurance in force at several points during the reporting year (or amounts in force at the beginning and at the end of the year), considering the length of the policy year if it differs from 12 months. Alternatively, the exposure may be calculated by dividing the earned premium by the annual premium rate per \$1,000 of outstanding insured indebtedness.</p> <p><b>Incurred Losses, to nearest dollar</b></p> <p>Incurred losses shall equal the claims paid plus the increase in claim reserves and liabilities. A negative number resulting from this calculation should be indicated by an X overpunch in column 31, 37 or 43.</p>
Columns 24-31	<b>Death benefits.</b>
32-37	<b>Disability benefits, lump sum benefits only.</b>
38-43	<b>Other, e.g., accidental death or dismemberment benefits.</b>
Column 44	<p><b>Age Limit</b></p> <p>Code 1 No age limit.          2 Age 65 at entry or 66 at maturity.          3 Any other age limit.</p>
Column 45	<p><b>Limits of Coverage</b></p> <p>Code 1 Limitation of coverage, on account of health conditions, for some or all of the insurance provided under the Experience Unit.          2 No such limitation for any of the coverage.</p>
Column 46	<p><b>Policy Provisions</b></p> <p>Code 1 All coverage under the Experience Unit is provided in accordance with the provisions of the Model Bill as to both:</p> <ul style="list-style-type: none"> <li>a. Disclosure and</li> <li>b. Mandatory cancellation of insurance at termination and refund of unearned insurance charge.</li> </ul> <p>2 Otherwise.</p>



STANLEY W. GINGERY  
Vice President and Associate Actuary

THE PRUDENTIAL  
INSURANCE COMPANY OF AMERICA  
HOME OFFICE

Prudential Plaza — Newark, N. J. 07101

May 24, 1968

Honorable Louis T. Mastos  
Insurance Commissioner  
Nevada Department of Commerce  
Insurance Division  
Carson City, Nevada 89701

Dear Commissioner Mastos:

A revised copy of Page 1 of the IAC's original report is enclosed. It shows the three numbers that were left blank in the original copy and corrects the typographical error in Line 7 of the third paragraph of Section 2 from Table IVa to Table IVb.

Subsequent to our mailing to the (E2) Subcommittee of the recent Report of the Industry Advisory Committee, it occurred to the IAC that some members of the (E2) Subcommittee might wish to see a more detailed description of the graduation process than it seemed appropriate to include in the formal report. We also enclose such a detailed description.

To put the problem and our proposed solution in its proper perspective, we are also enclosing copies of graphs 2A and 2B which are referred to in the detailed description of the graduation. These graphs show the crude data of the five plans included in the original study. They also show the composite of the crude data which was obtained by mechanically weighting the crude data adjusted to eliminate the malingering effect in retroactive plans.

Finally, the Committee thought that a table showing the differences between the graduated and crude results, as well as the ratio of graduated to crude results at six-month intervals for the credit A&H insurance plans included in the original study would be helpful in reviewing the report. In effect, the table summarizes the results of the graduation described in general terms in the report and in more detail in the enclosed description.

I have sent the foregoing material to the (E2) Subcommittee members and the various Trade Associations as you requested I do with the report itself, with the hope that it will expedite the deliberations of your Subcommittees at the Portland NAIC meeting.

I am looking forward to seeing you then. Please let me know if the IAC can be of further help.

Sincerely,

Stanley W. Gingery

cc: Industry Advisory Committee

MEMORANDUM

May 23, 1968

Additional Background on NAIC Credit A&H  
Insurance Experience Study and Development  
of the Graduated "1968 Basic Table of  
Credit A&H Claim Costs"

The framework of the development of the graduated version of the study leading to the recommendation being presented by the Industry Advisory Committee to the NAIC at its Portland, Oregon meeting follows:

1. Crude Claim Costs Used in Graduation
  - a. Were daily and monthly claim costs derived as the product of claim frequency and number disabled from Table I Crude Frequencies, and Table III, Continuation Tables respectively, published by the Industry Advisory Committee at the December, 1967 NAIC meeting in Hawaii.

- b. They were by plan of insurance for five plans — 7-day retroactive, 14 and 30-day retroactive and nonretroactive.
  - c. Were based on the experience by count (i.e., number of claims).
  - d. Showed little consistency as among the various plans of insurance and it appeared that it would be difficult and too time-consuming to produce a satisfactory composite table for use as a basic morbidity cost table for consideration at Hawaii.
  - e. At Hawaii, the IAC was asked to apply the actuarial knowledge and techniques at its disposal to produce an appropriate basic morbidity cost table. Graduation accomplished as described in the following.
2. Plots of Crude Claim Costs
- a. The claim costs by plan were plotted. See attached graphs 2A and 2B.
  - b. It was observed that a similar slope pattern existed among the plotted costs of the various plans.
  - c. Further examination of the costs of the 14 and 30-day retroactive and non-retroactive plans led to the conclusion that, to a great extent, the differences between the retroactive and nonretroactive plans was due to malingering. Rationale is that a disabled debtor is prone to continue on disability to the end of the waiting period to collect the benefit retroactive to first day of disability, thereby inflating cost.
  - d. Decision was to eliminate malingering effect before proceeding to derive a composite table.
3. Malingering Adjustment
- a. Relationship between the claim costs of 14-day retroactive and nonretroactive plans showed a malingering factor of approximately 15% on the first day after completion of the 14-day qualification period. This gradually diminished to zero at later durations of disability.
  - b. Under the 30-day plans, the retroactive claim cost was 37% higher than the nonretroactive on the first day following completion of the 30-day qualification period, grading off to about 18% in the later days of disability. Conclusion was that the retroactive claim costs were roughly 18% higher than the non-retroactive claim costs at the ultimate durations of disability. Therefore, the indicated malingering factor for the 30-day retroactive plan was 16%; i.e., 137% divided by 118% minus 1.
  - c. Since the indicated factor for the 14- and 30-day retroactive plans were so close (15% and 16%), 15% was taken to be the factor for all three retroactive plans — 7, 14 and 30-day.  
 To eliminate the malingering effect, the claim cost of the first day of disability following completion of the qualification period (i.e., the first day of compensable disability) was divided by 115%, the second day by 114%, etc., down to the point where the malingering effect became minimal. The latter was taken to be the 30th day of disability for the 14-day retroactive plan and the 46th day for the 30-day retroactive plan.
  - d. Foregoing adjustment produced adjusted claim costs by plan but independent of malingering; thereby setting stage for obtaining a composite table.
4. Composite
- a. Composite claim costs for the 31st and later days of disability were obtained by weighting the adjusted claim costs of the various plans by the product of the published number of claims originally entering the study times the published total days of disability by plan of insurance for 540 days; (540 days equals 18 months, which was taken to be a reasonable representation of the average initial duration of indebtedness entering the study).
  - b. For 30 and fewer days of disability, the weighting factors were adjusted to remove discontinuities at the points where the 14 and 30-day plans first entered the study and merged with the 7-day plan.  
 To obtain the adjusted weighting factor for 15 through 30 days of disability, the weighting factors of the 7- and 14-day plans applicable for 31 and later

days of disability were multiplied by the ratio of the composite 31-day cost to the portion of that cost arising from the 7- and 14-day plans.

The adjusted weighting factors were then applied to the crude claim costs of the 7- and 14-day plan to produce the composites for 15 through 30 days of disability.

The adjusted weighting factor of the 7-day plan for 15 through 30 days of disability was further adjusted by the ratio of the composite 15-day claim cost to the portion of that cost arising from the 7-day plan. This weighting factor when applied to the 7-day plan costs produced the composite costs for 8 through 14 days of disability.

- c. The compositing together with the malingering adjustment previously made had the effect of not reproducing the actual experience level of the original crude claim costs. This necessitated an adjustment further on in the graduation process to bring the graduated costs back to the study's true level (see 6. below).

#### 5. Preliminary Basic Cost Table

The weighted claim costs by day of disability from the foregoing produced a Preliminary Basic Cost Table; a composite table representative of all plans of insurance.

#### 6. Adjustment of Preliminary Basic Cost Table to Study Level

Adjusting the Preliminary Basic Cost Table back to the original claim cost level was accomplished by:

- a. From the published results, segregating the various periods of disability into blocks of 8 to 14 days, 15 to 30 days, 31 to 45 days, 46 to 180 days, 181 to 360 days, and 361 to 540 days.
- b. For each block of durations and plan of insurance separately, a factor representing the number of days of disability within each block under an 18-month loan was derived.

These factors by plan were then weighted by the exposures (based on count) from the published study, thereby producing an aggregate composite days of disability of the crude data.

- c. A similar aggregate days of disability was determined from the Preliminary Basic Cost Table for each of the subdivided blocks of days of disability.
- d. Dividing the aggregate days of disability from the published results by the aggregate obtained from the Preliminary Basic Cost Table gave an adjustment factor to be applied to the subdivided blocks from the Preliminary Basic Cost Table to adjust them to the original published study level.

#### 7. Basic Claim Cost Table

- a. Adjusting factors by block of days of disability described in 6. were applied to the subdivided claim costs of the Preliminary Basic Cost Table to obtain a Basic Claim Cost Table for days of disability after the 45th day.
- b. A graphic method was used for 45 or less days. This was subject to the requirement that the total days of disability obtained from the crude claim costs must be reproduced for each block of days of disability 8 through 14, 15 through 30, and 31 through 45 days.
- c. Since the Final Basic Claim Cost Table so produced was still based on number of claims — i.e., was by count, a further adjustment to a by-amount basis was needed (see 9. below).

#### 8. Claim Costs by Duration

- a. Single claim costs per \$100 of initial insured indebtedness for durations of 6, 12, 18 and 60 months were obtained from the Basic Claim Cost Table by count for each of the five plans in the published study.
- b. The costs of the 14-day retroactive plan exceeded those of the 7-day plan. This was probably due to a too close fit to the crude data, whose composition by type of creditor and by contributor varies as mentioned in paragraph 3 of Section 2 of IAC's report to the Special Task Force, Subcommittee (E2a). As a practical solution, the anomaly was dampened by imputing the excess cost of the 14-day plan to the 7-day plan by allowing the excess to apply back to the 8th through 14th day of disability. Accomplished by increasing the

daily claim costs by 6%, 5%, etc., down to 1%, for days of disability, 8, 9, etc., down to 13, respectively. This last adjustment produced the Final Basic Claim Cost Table based on count.

9. Basic Claim Cost Table by Amount

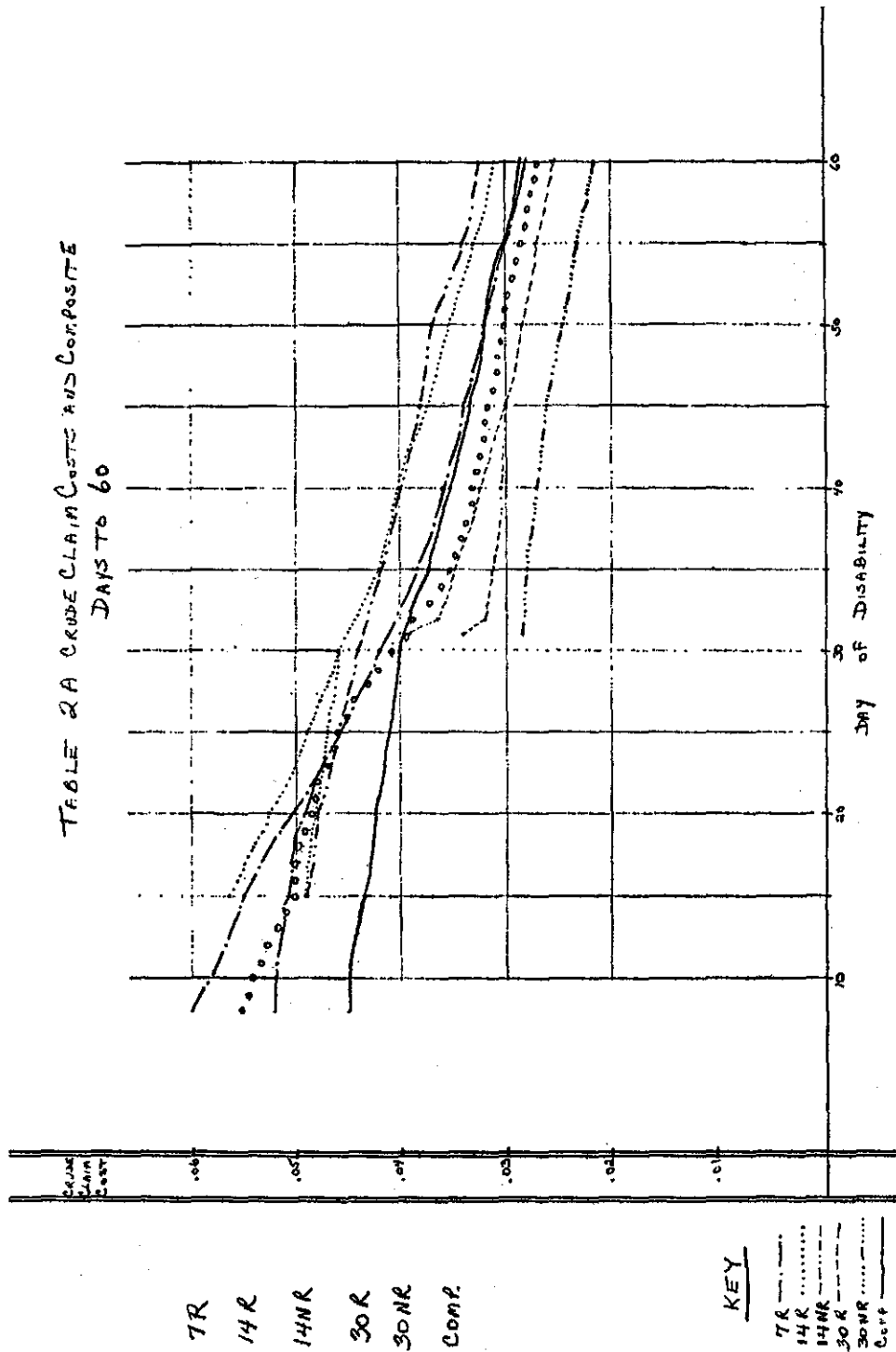
The table by amount was obtained by applying an adjustment factor of 5.705% to the claim costs in the Final Basic Claim Cost Table based on count through the first 30 days of disability. After the 30th day of disability the adjustment factor used was 4.865%.

10. Test of Graduation

A test of the over all goodness of the graduation using the days of disability computed from the graduated and crude results produced a ratio of graduated to crude of 99.9%.

Industry Advisory Committee

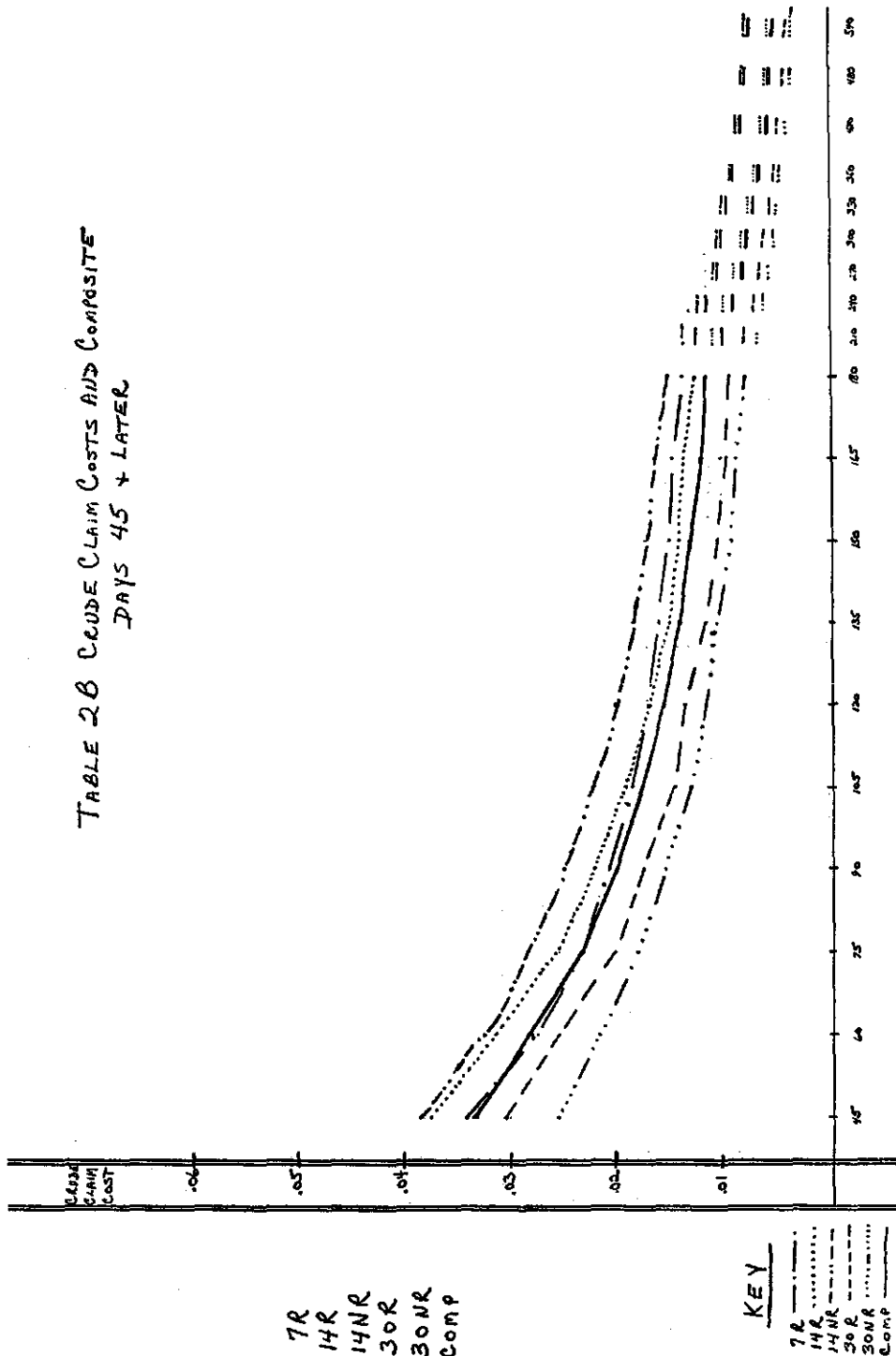
TABLE 2A CRUDE CLAIM COSTS AND COMPOSITE  
DAYS TO 60



TR  
14R  
14NR  
30R  
30NR  
COMP.

KEY  
TR ———  
14R - - - -  
14NR .....  
30R - · - -  
30NR - - - -  
Comp. ○ ○ ○

TABLE 2B CRUDE CLAIM COSTS AND COMPOSITE  
DAYS 45 + LATER



7R  
14R  
14NR  
30R  
30NR  
Comp

KEY

7R ———  
14R .....  
14NR - - - -  
30R - · - · -  
30NR - - - -  
Comp ———

## SUMMARY OF RESULTS OF GRADUATION

The attached Table shows single claim costs per \$100 as calculated from the 1968 Basic Table of Credit A & H Claim Costs, for five plans of benefits and how they compare with the crude results of the study as reported to the NAIC in December, 1967. (ref: 1968 Proc. Vol. I pp. 147-211).

The cost figures shown are single claim costs per \$100 initial indebtedness for original durations of indebtedness ranging from six months to five years.

- a. Single claim costs in accordance with the 1968 Basic Table, column (a).
- b. Single claim costs in accordance with crude results of the study. Results "by amount" are shown, column (b).
- c. The difference between the Basic Table and crude single claim costs, column (c) = column (a) - column (b).
- d. The relation of the Basic Table cost to the crude results, column (d) = column (a) ÷ column (b).

The crude results are those which were reported by the Industry Advisory Committee to the NAIC at its December, 1967 Hawaii meeting. The Basic Table represents the graduated results which the Industry Advisory Committee was requested to derive at that meeting in order to make it possible to have a method of obtaining consistent results for various combinations of waiting periods and durations of benefits.

Duration in Months	1968 Basic Table (a)	Crude Results (by Amount) (b)	(a)-(b) (c)	(a)/(b) (d)
7-Day Retro				
6	\$ .866	\$ .858	\$ .008	101%
12	1.200	1.248	-.048	96
18	1.416	1.528	-.112	93
24	1.588	1.761	-.173	90
30	1.724	1.967	-.243	88
36	1.849	2.154	-.305	86
42	1.963	2.327	-.364	84
48	2.069	2.489	-.420	83
54	2.167	2.642	-.475	82
60	2.260	2.786	-.526	81
14-Day Retro				
6	\$ .857	\$ .935	\$-.078	92%
12	1.195	1.328	-.133	90
18	1.412	1.582	-.170	89
24	1.579	1.779	-.200	89
30	1.721	1.946	-.225	88
36	1.847	2.095	-.248	88
42	1.961	2.231	-.270	88
48	2.066	2.355	-.289	88
54	2.165	2.473	-.308	88
60	2.258	2.583	-.325	87
30-Day Retro				
6	\$ .768	\$ .750	\$ .018	102%
12	1.117	1.081	.036	103
18	1.338	1.287	.051	104
24	1.508	1.444	.064	104
30	1.651	1.574	.077	105
36	1.777	1.688	.089	105
42	1.892	1.791	.101	106
48	1.998	1.885	.113	106
54	2.097	1.973	.124	106
60	2.190	2.055	.135	107
14-Day Nonretro				
6	\$ .619	\$ .723	\$-.104	86%
12	.947	1.168	-.221	81
18	1.160	1.480	-.320	78
24	1.326	1.731	-.405	77
30	1.467	1.950	-.483	75
36	1.592	2.148	-.556	74
42	1.706	2.328	-.622	73
48	1.811	2.497	-.686	73
54	1.909	2.653	-.744	72
60	2.002	2.804	-.802	71
30-Day Nonretro				
6	\$ .423	\$ .332	\$ .091	127%
12	.738	.566	.172	130
18	.947	.717	.230	132
24	1.111	.833	.278	133
30	1.251	.930	.321	135
36	1.375	1.014	.361	136
42	1.488	1.092	.396	136
48	1.592	1.163	.429	137
54	1.690	1.229	.461	138
60	1.783	1.292	.491	138



## Exhibit B

STANLEY W. GINGERY  
Vice President and Associate Actuary

THE PRUDENTIAL  
INSURANCE COMPANY OF AMERICA

## HOME OFFICE

Prudential Plaza — Newark, N. J. 07101

June 10, 1968

Honorable James Hunt  
Commissioner  
State of Vermont  
Department of Banking & Insurance  
Montpelier, Vermont 05602

Dear Commissioner Hunt:

This letter is in response to the request contained in your June 4 letter. You point out that the graduated "1968 Basic Table of Credit A&H Claim Costs" prepared by the Industry Advisory Committee produced graduated claim costs which were significantly less than the crude data results for 14-day plans and significantly higher for 30-day plans. This was the result of the apparent underlying inconsistencies in the data furnished by the various companies contributing to the study. You asked us to prepare an alternative to the 1968 Basic Table.

Following your suggestions, we have prepared two tables of Credit A&H claim costs. The first of these two tables was derived from the two plans with 14-day waiting periods, using the crude claim costs. The second table was derived similarly from the two 30-day plans. The techniques used to derive the two tables were similar to those described in the May 23, 1968 memorandum attached to my May 24 letter to the Industry Advisory Committee, copies of which went to the E-2 Subcommittee. Briefly, these steps were followed:

1. The malingering effect was eliminated from the basic data for the 14- and 30-day retroactive plans in the same way as for the 1968 Basic Table.
2. After that adjustment, the two 14-day plan claim costs and the two 30-day claim costs were composited by weighting the adjusted claim costs by the product of the published number of claims originally entering the study times the published total days of disability by plan of insurance for 540 days.

Claim costs back to the eighth day of disability were obtained by extrapolating the composite claim costs of the 14-day plans. The crude data of the 7-day retroactive plan were completely disregarded in determining the levels of claim costs since that plan's crude data produced single claim costs per \$100 of initial insured indebtedness which at most durations were either less than, or only slightly higher than, the corresponding single claim costs for a 14-day retroactive plan. Because of the relatively small amount of 7-day retroactive plan data in the study, no attempt was made to use it, the assumption being that the inconsistencies were in the 7-day plan data. The extrapolation from the 14-day data to 7 days was intended to produce reasonable results.

As a result of our work, we are attaching three tables:

1. Table 1 shows Credit A&H claim costs per \$1 by day of disability and additional functions needed to compute single claim costs, derived from the crude data for 14-day plans.
2. Table 2 shows similar functions derived from the crude data for 30-day plans.
3. Table 3 compares single claim costs per \$100 of initial insured indebtedness for various durations as determined from the appropriate one of the foregoing 14-day and 30-day tables with the crude single claim costs and with the single claim costs produced by the previous mechanical graduation which merged all plans (referred to as the 1968 Basic Table).

I understand it is your thought that the two tables might be appropriately used in the following fashion:

1. For waiting periods of 7 through 14 days, the table derived from the two 14-day plans would be used.
2. For waiting periods of 30 days or more, the table derived from the two 30-day plans would be used.

The two-table approach has a virtue of generally reproducing the crude data quite closely, as shown in table 3, particularly for the plans with the largest amount of crude data, namely, the 14-day retroactive plan and the 30-day nonretroactive plan. It has a disadvantage as compared with the Industry Advisory Committee's report, of not constituting a single composite table from which consistent values for all plans from 7 days on would be available. We understand it is your thought that values for plans with waiting periods between 14 and 30 days would be derived from the two-table approach by straight line interpolation, in the rare instances where such plans are used.

Copies of the enclosures are being sent to Commissioner Mastos and to the members of the E-2 Subcommittee in order that they may consider this alternative method of graduating the crude data which you have requested prior to the convening of the Portland meeting.

We are also sending the enclosures (and your June 4 letter) to the members of the Industry Advisory Committee at this time so that they may consider them and submit comments to me by telephone or wire prior to the Portland meeting, if they care to do so.

As in the case of the Industry Advisory Committee's report of April 26 and the supplementary material of May 24, I am also sending copies of the enclosures to representatives of the interested trade associations.

I trust that you will find the enclosures satisfactory and in keeping with your request.

Best regards.

Sincerely,

Stanley W. Gingery

STATE OF VERMONT  
DEPARTMENT OF BANKING AND INSURANCE  
DIVISION OF INSURANCE  
MONTPELIER 05602

June 4, 1968

Mr. Robert Younger  
Prudential Insurance Company of America  
Prudential Plaza  
Newark, New Jersey 07101

Dear Bob:

I have been reviewing the work the Advisory Committee has done in graduating the results of the Credit Health Insurance Morbidity Study resulting in a basic table which might be used to develop single claim costs for any particular plan of coverage.

There is little question that the graduation has been skillfully accomplished as evidenced by the 99.9% "fit". Nevertheless, it is equally clear that the basic table represents essentially an average of two somewhat dissimilar data groups. I refer to those plans with a shorter elimination period — 14 days and 7 days, retroactive and non-retroactive — and, on the other hand, those plans with the longer elimination period. It seems to me that an alternative approach might be useful in heading off criticism which inevitably will be made that the basic table is not really representative of anything.

Obviously, five basic tables would be too confusing but perhaps two basic tables would better serve our purposes.

Undoubtedly, the co-chairmen of the Advisory Committee are quite aware of this problem which I see and possibly would see some merit in presenting an alternative to the various subcommittees meeting in Portland.

Best regards.

Sincerely,

James H. Hunt, Commissioner

Department of Banking  
and Insurance

JHH/pa

TABLE 1  
COMPOSITE OF 14 DAY PLANS

Day of Disa- bility	End of Month	d C t	d M t	d R t	Day of Disa- bility	End of Month	d C t	d M t	d R t
t					t				
8		.05620	.05620	.05620	46		.03899	1.86307	39.35667
9		.05560	.11180	.16800	47		.03850	1.90157	41.25824
10		.05490	.16670	.33470	48		.03798	1.93955	43.19779
11		.05420	.22090	.55560	49		.03749	1.97704	45.17483
12		.05360	.27450	.89010	50		.03700	2.01404	47.18887
13		.05300	.32750	1.15760	51		.03660	2.05064	49.23951
14		.05250	.38000	1.53760	52		.03619	2.08683	51.32634
15		.05200	.43200	1.96960	53		.03579	2.12262	53.44896
16		.05169	.48369	2.45329	54		.03538	2.15800	55.60696
17		.05130	.53499	2.98828	55		.03494	2.19294	57.79990
18		.05108	.58607	3.57435	56		.03448	2.22742	60.02732
19		.05084	.63691	4.21126	57		.03404	2.26146	62.28878
20		.05061	.68752	4.89878	58		.03367	2.29513	64.58391
21		.05035	.73787	5.63665	59		.03328	2.32841	66.91232
22		.04992	.78779	6.42444	60	2	.03291	2.36132	69.27364
23		.04959	.83738	7.26182					
24		.04941	.88679	8.14861	61		.03251	2.39383	71.66747
25		.04927	.93606	9.08467	62		.03174	2.42557	74.09304
26		.04911	.98517	10.06984	63		.03133	2.45690	76.54994
27		.04897	1.03414	11.10898	64		.03096	2.48786	79.03780
28		.04877	1.08291	12.18689	65		.03057	2.51843	81.55623
29		.04850	1.13141	13.31830	66		.03020	2.54863	84.10486
30	1	.04833	1.17974	14.49804	67		.02990	2.57853	86.68339
					68		.02958	2.60811	89.29150
31		.04735	1.22709	15.72513	69		.02924	2.63735	91.92885
32		.04600	1.27309	16.99822	70		.02893	2.66628	94.59513
33		.04544	1.31853	18.31675	71		.02863	2.69491	97.29004
34		.04489	1.36342	19.68017	72		.02833	2.72324	100.01323
35		.04434	1.40776	21.08793	73		.02802	2.75126	102.76454
36		.04374	1.45150	22.53943	74		.02772	2.77898	105.54352
37		.04319	1.49469	24.03412	75		.02741	2.80639	108.34991
38		.04277	1.53746	25.57158					
39		.04233	1.57979	27.15137	76		.02709	2.83348	111.18339
40		.04189	1.62168	28.77305	77		.02679	2.86027	114.04366
41		.04147	1.66315	30.43620	78		.02649	2.88676	116.93042
42		.04100	1.70415	32.14035	79		.02623	2.91299	119.84341
43		.04045	1.74460	33.88495	80		.02595	2.93894	122.78235
44		.03997	1.78457	35.66952	81		.02569	2.96463	125.74698
45		.03951	1.82408	37.49360	82		.02541	2.99004	128.73702
					83		.02516	3.01520	131.75222
					84		.02493	3.04013	134.79235
					85		.02469	3.06482	137.85717
					86		.02444	3.08926	140.94643
					87		.02421	3.11347	144.05990
					88		.02395	3.13742	147.19732
					89		.02368	3.16110	150.35842
					90	3	.02344	3.18454	153.54296

TABLE 1  
COMPOSITE OF 14 DAY PLANS

Day of Disability	End of Month	d C t	d M t	d R t	Day of Disability	End of Month	d C t	d M t	d R t
90	3	.02344	3.18454	153.54296	930	31	.00452	9.54981	6158.27983
120	4	.01837	3.79669	258.92741	960	32	.00446	9.68447	6446.86654
150	5	.01536	4.29568	380.77662	990	33	.00438	9.81704	6739.46036
180	6	.01320	4.72120	516.39758	1020	34	.00432	9.94761	7036.00016
210	7	.01159	5.09033	663.87220	1050	35	.00426	10.07625	7336.42685
240	8	.01033	5.41765	821.74643	1080	36	.00419	10.20305	7640.68421
270	9	.00914	5.70760	988.85508	1110	37	.00414	10.32810	7948.71756
300	10	.00842	5.97014	1164.20411	1140	38	.00409	10.45151	8260.47702
330	11	.00783	6.21274	1347.10686	1170	39	.00404	10.57337	8575.91452
360	12	.00729	6.43896	1537.03456	1200	40	.00398	10.69375	8894.98524
390	13	.00685	6.65032	1733.51823	1230	41	.00394	10.81275	9217.64564
420	14	.00649	6.85030	1936.16016	1260	42	.00390	10.93042	9543.85471
450	15	.00624	7.04117	2144.64314	1290	43	.00386	11.04683	9873.57488
480	16	.00603	7.22519	2358.74527	1320	44	.00382	11.16203	10206.76773
510	17	.00587	7.40345	2578.27311	1350	45	.00379	11.27608	10543.39887
540	18	.00569	7.57676	2803.07308	1380	46	.00374	11.38901	10883.43454
570	19	.00558	7.74584	3033.00579	1410	47	.00371	11.50085	11226.84021
600	20	.00546	7.91138	3267.95526	1440	48	.00368	11.61165	11573.58512
630	21	.00536	8.07364	3507.81959	1470	49	.00364	11.72144	11923.63869
660	22	.00526	8.23236	3752.50399	1500	50	.00361	11.83023	12276.96995
690	23	.00517	8.38923	4001.92043	1530	51	.00358	11.93807	12633.55014
720	24	.00509	8.54294	4255.98637	1560	52	.00354	12.04497	12993.35114
750	25	.00499	8.69409	4514.62334	1590	53	.00352	12.15099	13356.34574
780	26	.00492	8.84272	4777.75646	1620	54	.00349	12.25612	13722.50701
810	27	.00483	8.98837	5045.30943	1650	55	.00346	12.36041	14091.80895
840	28	.00475	9.13260	5317.20931	1680	56	.00344	12.46388	14464.22714
870	29	.00468	9.27396	5593.38424	1710	57	.00341	12.56654	14839.73613
900	30	.00459	9.41300	5873.76372	1740	58	.00339	12.66842	15213.31331
					1770	59	.00336	12.76953	15599.93464
					1800	60	.00333	12.86990	15984.57817

TABLE 2  
COMPOSITE OF 30 DAY PLANS

Day of Disa- bility	End of Month	d C t	d M t	d R t	Day of Disa- bility	End of Month	d C t	d M t	d R t
t					t				
31		.03081	.03081	.03081	76		.01905	1.15018	29.26673
32		.03048	.06129	.09210	77		.01884	1.16902	30.43580
33		.03057	.09166	.18376	78		.01866	1.18768	31.62348
34		.03020	.12186	.30562	79		.01847	1.20615	32.82963
35		.03000	.15186	.45748	80		.01830	1.22445	34.05408
36		.02977	.18163	.63911	81		.01809	1.24254	35.29662
37		.02957	.21120	.85031	82		.01791	1.26045	36.55707
38		.02936	.24056	1.09087	83		.01772	1.27817	37.83524
39		.02911	.26967	1.36054	84		.01754	1.29571	39.13095
40		.20890	.29857	1.65911	85		.01738	1.31309	40.44404
41		.02869	.32726	1.98637	86		.01722	1.33031	41.77435
42		.02840	.35566	2.34203	87		.01706	1.34737	43.12172
43		.02812	.38378	2.72581	88		.01689	1.36426	44.48598
44		.02786	.41164	3.13745	89		.01672	1.38098	45.86696
45		.02758	.43922	3.57667	90	3	.01654	1.39752	47.26448
46		.02730	.46652	4.04319	120	4	.01237	1.81990	96.02775
47		.02697	.49349	4.53668					
48		.02664	.52013	5.05631	150	5	.00989	2.14798	155.88481
49		.02631	.54644	5.60325					
50		.02601	.57245	6.17570	180	6	.00836	2.41852	224.62660
51		.02574	.59819	6.77339					
52		.02548	.62367	7.39756	210	7	.00716	2.64885	300.83528
53		.02520	.64887	8.04643					
54		.02495	.67382	8.72025	240	8	.00635	2.85028	383.48019
55		.02466	.69848	9.41873					
56		.02439	.72287	10.14160	270	9	.00576	3.03063	471.82747
57		.02415	.74702	10.88862					
58		.02390	.77092	11.65954	300	10	.00524	3.23034	565.32615
59		.02365	.79457	12.45411					
60	2	.02334	.81791	13.27202	330	11	.00482	3.34493	663.52555
61		.02299	.84090	14.11292	360	12	.00446	3.48371	766.05407
62		.02241	.86331	14.97623					
63		.02207	.88538	15.86161	390	13	.00415	3.61229	872.57870
64		.02180	.90718	16.76879					
65		.02156	.92874	17.69753	420	14	.00392	3.73268	982.32895
66		.02130	.95004	18.64757					
67		.02104	.97108	19.61865	450	15	.00370	3.84741	1096.60227
68		.02078	.99186	20.61051					
69		.02055	1.01241	21.62292	480	16	.00353	3.89584	1213.71647
70		.02033	1.03274	22.65566					
71		.02009	1.05283	23.70849	510	17	.00339	4.05938	1334.00758
72		.01988	1.07271	24.78120					
73		.01968	1.09239	25.87359	540	18	.00323	4.15852	1457.33445
74		.01949	1.11188	26.98547					
75		.01925	1.13113	28.11660					

TABLE 2  
COMPOSITE OF 30 DAY PLANS

Day of Disa- bility	End of Month	d C t	d M t	d R t	Day of Disa- bility	End of Month	d C t	d M t	d R t
t					t				
540	18	.00323	4.15852	1457.33445	1200	40	.00227	5.92643	4820.90070
570	19	.00317	4.25442	1583.58184	1230	41	.00223	5.99393	4999.74184
600	20	.00309	4.34832	1712.67468	1260	42	.00221	6.06067	5180.59580
630	21	.00304	4.44035	1844.55514	1290	43	.00219	6.12669	5363.44093
660	22	.00298	4.53066	1979.16950	1320	44	.00217	6.19203	5548.25614
690	23	.00294	4.61935	2116.46777	1350	45	.00215	6.25672	5735.02149
720	24	.00288	4.70653	2256.40318	1380	46	.00213	6.32078	5923.71704
750	25	.00283	4.79225	2398.93146	1410	47	.00211	6.38421	6114.32494
780	26	.00279	4.87655	2544.00934	1440	48	.00209	6.44705	6306.82677
810	27	.00274	4.95945	2691.59439	1470	49	.00207	6.50932	6501.20475
840	28	.00270	5.04097	2841.64498	1500	50	.00204	6.57103	6697.44194
870	29	.00265	5.12115	2994.12023	1530	51	.00203	6.63219	6895.52130
900	30	.00261	5.20001	3148.98019	1560	52	.00201	6.69283	7095.42839
930	31	.00257	5.27761	3306.18644	1590	53	.00199	6.75296	7297.14604
960	32	.00253	5.35398	3465.70143	1620	54	.00198	6.81259	7500.66024
990	33	.00249	5.42918	3627.48920	1650	55	.00196	6.87174	7705.95576
1020	34	.00245	5.50324	3791.51476	1680	56	.00195	6.93042	7913.01837
1050	35	.00241	5.57620	3957.74521	1710	57	.00193	6.98865	8121.83441
1080	36	.00238	5.64812	4126.14809	1740	58	.00192	7.04643	8332.39051
1110	37	.00235	5.71905	4296.69321	1770	59	.00191	7.10373	8544.67352
1140	38	.00232	5.78904	4469.35152	1800	60	.00189	7.16071	8758.67026
1170	39	.00229	5.85815	4644.09593					

Table 3  
 Comparison of Single Claim Costs per \$100 Initial Indebtedness  
 Based on Two Composite Tables — 14 & 30 Day Separately, 1968 Basic Table and  
 Crude Results

Duration in Months	Two Composite Tables (a)	1968 Basic Table (b)	Crude Results (by Amount) (c)	(a)-(b) (d)	(a)/(b) (e)	(a)-(c) (f)	(a)/(c) (g)
7-Day Retroactive							
6	\$ .918	\$ .866	\$ .858	\$ .052	106%	\$ .060	107%
12	1.309	1.200	1.248	.109	109	.061	105
18	1.566	1.416	1.528	.150	111	.088	102
24	1.766	1.583	1.761	.183	112	.005	100
30	1.938	1.724	1.967	.214	112	-.029	99
36	2.090	1.849	2.154	.241	113	-.064	97
42	2.229	1.963	2.327	.266	114	-.098	96
48	2.358	2.069	2.489	.289	114	-.131	95
54	2.478	2.167	2.642	.311	114	-.164	94
60	2.592	2.260	2.786	.332	115	-.194	93
14-Day Retroactive							
6	\$ .912	\$ .857	\$ .935	\$ .055	106%	\$ -.023	98%
12	1.307	1.195	1.328	.112	109	-.021	98
18	1.565	1.412	1.582	.153	111	-.017	99
24	1.766	1.579	1.779	.187	112	-.013	99
30	1.937	1.721	1.946	.216	113	-.009	100
36	2.090	1.847	2.095	.243	113	-.005	100
42	2.229	1.961	2.231	.268	114	-.002	100
48	2.358	2.066	2.355	.292	114	.003	100
54	2.479	2.165	2.473	.314	115	.006	100
60	2.593	2.258	2.583	.335	115	.010	100
30-Day Retroactive							
6	\$ .593	\$ .768	\$ .750	\$ -.175	77%	\$ -.157	79%
12	.862	1.117	1.081	-.255	77	-.219	80
18	1.029	1.338	1.287	-.309	77	-.258	80
24	1.153	1.508	1.444	-.355	76	-.291	80
30	1.257	1.651	1.574	-.394	76	-.317	80
36	1.348	1.777	1.688	-.429	76	-.340	80
42	1.430	1.892	1.791	-.462	76	-.361	80
48	1.506	1.998	1.885	-.492	75	-.379	80
54	1.576	2.097	1.973	-.521	75	-.397	80
60	1.642	2.190	2.055	-.548	75	-.413	80
14-Day Non-Retroactive							
6	\$ .697	\$ .619	\$ .723	\$ .078	113%	\$ -.026	96%
12	1.083	.947	1.168	.136	114	-.085	93
18	1.338	1.160	1.480	.178	115	-.142	90
24	1.538	1.326	1.731	.212	116	-.193	89
30	1.708	1.467	1.950	.241	116	-.242	88
36	1.861	1.592	2.148	.269	117	-.287	87
42	1.999	1.706	2.328	.293	117	-.329	86
48	2.128	1.811	2.497	.317	118	-.369	85
54	2.248	1.909	2.653	.339	118	-.405	85
60	2.362	2.002	2.804	.360	118	-.442	84
30-Day Non-Retroactive							
6	\$ .347	\$ .423	\$ .332	\$ -.076	82%	\$ .015	105%
12	.591	.733	.566	-.147	80	.025	104
18	.750	.947	.717	-.197	79	.033	105
24	.871	1.111	.833	-.240	78	.038	105
30	.972	1.251	.930	-.279	78	.042	105
36	1.061	1.375	1.014	-.314	77	.047	105
42	1.142	1.488	1.092	-.346	77	.050	105
48	1.217	1.592	1.163	-.375	76	.054	105
54	1.286	1.690	1.229	-.404	76	.057	105
60	1.352	1.783	1.292	-.431	76	.060	105



## Life Insurance (E4) Subcom. Report

(Mtg. 10)

The Life Insurance (E4) Subcommittee met in Ballroom B of the Portland Hilton Hotel on June 17, 1968.

In Executive Session it was determined that this Subcommittee would initiate a study into the marketing of life insurance in correlation with equity securities. It was the consensus of this Subcommittee that this might well be included as a research project conducted by the NAIC staff as a supplement to the recent report on variable annuity regulations.

Hon. Frank R. Montgomery, Chm., W. Va.; Hon. Robert D. Scharz, V.Chm., Mo.; Hon. Walter S. Houseal, Ala.; Hon. Albert F. Jordan, D. C.; Hon. John F. Bolton, Jr., Ill.; Hon. Thomas C. Hunt, Minn.; Hon. Elmer V. Omholt, Mont.; Hon. Richard E. Stewart, N. Y.; Hon. James R. Faulstich, Ore.; Hon. Julio R. Hernandez, P. R.; Hon. Durwood Manford, Tex.; Hon. Robert D. Haase, Wis.

Non-Profit Hospital and Medical Service Associations  
(E5) Subcom. Report (Mtg. 6)

The meeting was called to order by Chairman Hon. Lorne R. Worthington with the States of Iowa, Florida, California, Delaware, Idaho, Louisiana and Nevada present. The National Association of Blue Shield Plans and the Blue Cross Association submitted their Annual Report on the current status of research projects and studies concerning prepayment and hospital and medical care economics. Representing the NABSP and BCA were Artemis Leslie, George Heitler and William E. Timmons. The Subcommittee received their report and the Chairman extended on behalf of the Subcommittee, his appreciation for the work and effort that had gone into the preparation of this report.

With no further business before the Subcommittee, the Subcommittee adjourned into executive session. During the executive session, the following motion was adopted.

Be it resolved that the Non-Profit Hospital and Medical Service Associations (E5) Subcommittee requests the NABSP and BCA to update their study of claim reserves as presented to the regular meeting of the NAIC of December, 1967, so that it reflects current claim reserves, including any other reserve funds which a plan may have, stating the nature and need therefor.

It was further suggested that Commissioners individually study the filed expenses of plans in their jurisdiction in relationship to income, with emphasis placed on such items as travel expense, salaries, advertising and printing costs, and the results of such studies be made available to this Subcommittee. This motion was seconded and unanimously carried.

Hon. Lorne R. Worthington, Chm., Iowa; Hon. Broward Williams, V.Chm., Fla.; Hon. Walter S. Houseal, Ala.; Hon. Richard S. L. Roddis, Calif.; Hon. Robert A. Short, Dela.; Hon. John R. Blaine, Idaho; Hon. Joseph G. Wood, Ind.; Hon. Dudley A. Guglielmo, La.; Hon. Thomas C. Hunt, Minn.; Hon. Louis T. Mastos, Nev.; Hon. Julio R. Hernandez, P. R.; Hon. Clay Cotten, Texas.

**BLUE CROSS and BLUE SHIELD**

Blue Cross Association

840 North Lake Shore Drive

Chicago, Illinois 60611

National Association of Blue Shield Plans

211 East Chicago Avenue, Chicago, Illinois 60611

May, 1968

To: The Honorable Lorne R. Worthington, Chairman, Non-Profit Hospital and Medical Service Associations Subcommittee.

The National Association of Blue Shield Plans and the Blue Cross Association herewith submit the annual report on the current status of research projects and studies concerning prepayment and hospital and medical care economics.

The principal investigators of projects were requested to submit a standard abstract form to the Associations, stating the problems under study, methods of investigation used, and principal findings. Abstracts were solicited from researchers whose work had been reported as being in progress in the 1967 report and from those who had initiated studies in the interim, including those referred by state Commissioners of Insurance.

The report groups studies alphabetically by state. In assigning studies to states, preference was generally given to the population under study. However, studies involving more than one state have been grouped according to the location of the investigator, and identified by asterisk in the Table of Contents. An Appendix has been prepared grouping studies under general headings, primarily based upon the problems under study.

The responsibility for soliciting, compiling, editing and organizing the abstracts included in this report was given to the Research Department of the National Association of Blue Shield Plans, assisted by the Division of Research of the Blue Cross Association. William J. Sobaski directed the efforts of Mrs. Hannah Lapp, Mrs. Brendlin Niblack, and Mr. Derven Fullar of NABSP, and coordinated with Mr. D. Brian Heller and Miss Virginia Davis of BCA.

In the interests of timeliness, and to reflect the investigators' own statements of purposes and conclusions, only minimal editorial changes were made. The 1968 report encompasses 265 studies conducted or investigated in 38 states, territories and districts, and reflects activities of 56 universities and colleges, 30 state and local government agencies, 25 prepayment and/or insurance organizations, 17 local and 7 national hospital, medical or professional organizations, 11 local or regional planning organizations, 17 other private research or health organizations, and at least eight federal or federally sponsored agencies, institutes and commissions. Their magnanimous cooperation is appreciated.

Respectfully submitted,

James E. Veney, Ph.D., Director  
Division of Research  
Blue Cross Association

William J. Sobaski  
Director of Research  
National Association of Blue Shield Plans

## ANNUAL REPORT

May 1968

## SELECTED ABSTRACTS

Prepaid Hospital and Medical Economics Studies

1968 Research Report: National Association of Insurance Commissioners

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- 5 Patients, Physicians, and the General Hospital: A Social Survey of Decisions and Use in Massachusetts, 1960-61
- 6 An Economic Analysis of the Short-Term, Voluntary, General Hospital
- 7 Returns to Scale in the Production of Hospital Services
- 8 Geriatric Rehabilitation in a Community Hospital
- 9 Determination of the Amount and Kinds of Nursing Care Required by Nursing Home Patients

- \*10 Demand for Medical Care Facilities
  - 11 Demonstration of Automated Instruction for Diabetic Self-Care
  - 12 Analysis of a Hospital Ambulance Service
  - 13 Extended Benefits Case Reserve Requirements Analysis
  - 14 Enrollment Average Family Size; Age/Sex Distribution of Enrollees
  - 15 Analysis of Health Services by Geographic Area
  - 16 Doctor's Profile of Out-Patient Practice
  - 17 Blue Cross Data Service
  - 18 Patient Profiles III and IV
  - 19 Home Health Care Utilization Project
  - 20 Economic Returns to Health Services (Exploratory Study)
  - 21 Hard-to-Reach Families in a Comprehensive Care Program
  - 22 On the Reliability of Family Health Information
- Michigan
- 1 Involvement of Top Decision-Makers as an Instrument to Promote Change in the Organization and Financing of Community Health Services
  - 2 Patterns of Social Differentiation Between CHA and Blue Cross-Blue Shield
  - 3 Consumer Satisfaction with Group Practice, The CHA Case
  - 4 Evaluation of Progressive Patient Care at McPherson Community Health Center, Howell, Michigan
  - 5 Big Bill Study
  - 6 Costs of Patient Care Programs in Mental Hospitals
  - 7 Patient Discharge Survey
  - 8 Ecology of Employment Termination
  - 9 Medical Care of the Very Aged
  - 10 Demand for Health Insurance Coverage in a Metropolitan Population
- Minnesota
- 1 Value of Demographic and Social Data to Hospitals
  - \*2 "Modern Medicine" Poll of Medical Practice Cancer of the Breast
  - 3 A Demonstration of Reducing Hospital Operating Costs by the Sharing of Services
  - 4 A Study of the University of Minnesota Hospital Drug Distribution
  - 5 Health Care and the Family: A Three Generational Study
  - 6 A Study of the Patient Pattern of Payment by Medical Specialty
  - 7 Provisions for Pharmaceutical Services in Small Minnesota Hospitals
  - 8 Application of Automatic Data Processing Equipment to the Control of Restricted Drugs in the Hospital
  - 9 Medical Auditing in a Comprehensive Clinic Program
- Missouri
- 1 The Service Manager System: Nurse Efficacy and Cost
  - 2 Hospital Employee Group Plan Utilization of In-Patient Service at Place of Employment Vs. Other Hospital
  - 3 Cost Factors in a Hospital-Based Home Care Program
  - \*4 Relative Value Service Study 1968 (Optometry)



## Nebraska

- 1 Medical Expense as a Factor in Bankruptcy

## New Jersey

- 1 Research and Characteristics of Patients at New Jersey General Hospitals
- 2 Physician Specialty and Age, New Jersey 1967

## New York

- 1 Evaluation of Impact of 1965 Social Security Amendments on Distribution of Medical Services
- 2 Ambulatory Care Services in New York City
- 3 Hospital Staff Appointments
- 4 Assignment of Public Health Nurses to Acute General Hospitals to Plan for Care after Discharge
- 5 The Three "R's" of Psychiatric Treatment Statistics
- 6 An Analysis of Health Insurance Experience and the Use of a Diagnostic and Advice Center by Thirteen Welfare Funds
- 7 Report of Interviews with Selected Teamster Families: Attitudes, Utilization and Out-of-Pocket Costs for Health Studies
- 8 Health Referral Service for Armed Forces Rejectees
- 9 Western New York Inventory of Community Health Services for Cardiovascular Disease
- 10 A Description of the Barriers to Employment Faced by Persons with Cardiac Disease
- 11 Comprehensive and Prolonged Bedside Care
- 12 A Study of Motivational Factors in Nursing Home Patients
- 13 Use and Cost of A.H.S. Coordinated Home Care Programs
- 14 Drug Utilization and Costs for Patients with Acute Myocardial Infarction
- 15 An Evaluation of Observer Variability in a Hospital Bed Utilization Study
- 16 Study of Use of Maternity Beds by Selected Gynecological Patients
- 17 Community Services Research and Development Program
- 18 End Result Measurement of Quality of Medical Care
- 19 Patterns of Medical Use by the Indigent Aged Under Two Systems of Medical Care
- 20 Cost and Care of Children with Cystic Fibrosis of Pancreas
- 21 Psychiatric Treatment and Patterns of Medical Care
- 22 Economic Factors Affecting the Costs of Prescription Drugs in the Greater Metropolitan Area of New York
- 23 Delineation of Methods for Evaluating and Appraising Medical Care Programs Through Utilization Review and Medical Audit
- 24 Physicians and Medicare: A Study of Attitude Change
- 25 The Erie County Survey of Long-Term Childhood Illness
- 26 Utilization of Professional Personnel in the New York City School Health Service
- \*27 Health Insurance Association of America Studies
- \*28 Medical Care for the Elderly Before and After Medicare
- 29 Need for Nursing Home Beds in Cattaraugus and Chautauqua Counties

- 30 Development and Maintenance of Two Population Laboratories for the Study of the Distribution of Mental Disorders and the Determinants of These Distributions
- \*31 National Tuberculosis Association Collaborative Interdisciplinary Out-patient Research and Demonstration Project
- 32 Charges for Complex Surgery
- \*33 Hospital-Based Specialists Study: Pathologists' and Radiologists' Arrangements with Hospitals, 1966 and 1965
- 34 Personal Health Services: Utilization and Charges
- 35 A Study of Hospital Costs in New York State
- 36 Evaluation of Chronic Disease Screening Programs
- 37 Inquiry into the Implementation of the Recommendations of the Governor's Committee on Hospital Costs (1965)
- \*38 A Study of the Effects of Medicaid on Health Resource Utilization and Other Health Practices of Low-Income Persons
- 39 Residency Training in Community Psychiatry
- 40 Training in Community Mental Health
- 41 New Methods of Establishing a Continuum of Community Care for Problem Drinkers
- 42 A Day-Night Center for Addicted Persons
- 43 Insured Dental Care
- 44 Physician Service Patterns and Illness Rates
- 45 Medical Care of Infants and Preschool Children
- 46 Characteristics of Physicians Engaged in Private Practice in a Neighborhood of New York City
- \*47 1966 Inventory of Registered Nurses and Facts About Nursing (Annual)
- 48 Study and Evaluation to Identify and Determine Reasons for Variations in the Cost of Providing Hospital Services
- 49 An Analysis of the Components of Rising Hospital Costs
- 50 Utilization Review Process
- 51 Analysis of a Nursing Audit
- 52 Economic Behavior of the Proprietary Hospital
- North Carolina
- 1 Household Activity Patterns and Community Health
- 2 Extension of Prepayment to Out-of-Hospital Services
- Ohio
- 1 Role Conceptions of Pharmacy and Community Health
- 2 Task Allocation and Structure of Health Resources
- 3 Computer Systems as Related to Teaching and Research Program of the College of Medicine
- 4 Evaluation of Disability and Rehabilitation Potential
- \*5 Population Trends in the Eight-County Ohio-Kentucky-Indiana Regional Planning Authority Area
- 6 Continued Care by Nurses and Doctors: An Experiment
- 7 Determination of the Value and Need of a Continuity of Care Program and Cost
- 8 Use of ECF's in the Greater Cincinnati Area

- 9 Hospital Utilization in the Greater Cincinnati Health Service Area
- 10 Emergency Room Utilization
- 11 Predicting Judged Quality of Patient Care in General Hospitals
- 12 Cleveland Health Goals Projects: Description and Analysis of Comprehensive Health Planning in a Metropolitan Area
- \*13 Design of Prepaid Dental Plans
- Oklahoma
- 1 Project Responsibility—A Project in the Packaging and Delivery of Health Services in Rural Communities to be Based on Studies of Rural Health Manpower, Health Services and Health Facilities
- 2 The Study of Costs, Utilization, and Financing of Health and Medical Service in Oklahoma
- Oregon
- 1 Economic Efficiency of Medical Services Market
- Pennsylvania
- 1 Focus on Emotionally Disturbed Children
- 2 Hospital Utilization Review
- 3 The Homebound Patient—Dental Needs and Methods for Providing Dental Care
- 4 Health Needs and Utilization of Health Services and Facilities: Sullivan County Health Survey, 1964
- 5 Homemaker and/or Home Health Aide Survey
- 6 Health Maintenance Study of a Selected Group of Older People
- 7 Physician and Patient Attitudes Toward a Hospital Home Care Program
- \*8 Duration of Maternal Postpartum Hospital Stay—An Economic or Medical Problem?
- \*9 The Attitudes and Anticipated Behavior of Dentists Toward Reimbursement Plans
- 10 An Evaluation of the Use of the Photofluorographic Examination
- 11 A Model Prescription Recording System
- 12 Hospital-Based Cervical Cancer Detection Program
- 13 Analysis of Private Duty Nursing
- 14 Hospital Cost Trends
- 15 Hospital Income Survey
- 16 Hospital Utilization of Pittsburgh Residents by Socio-Economic Status (Census Tract), 1963 Progress Report
- 17 Determinants of the Volume of Service Provided to Maternity Patients
- 18 Methodology in Evaluating the Quality of Medical Care—An Annotated Selected Bibliography—1962-1967
- Puerto Rico
- 1 Continuing Master Sample Survey of Health and Welfare Services
- 2 Demonstration Program for Dental Care for the Aged and/or Chronically Ill
- Rhode Island
- 1 Area Hospital Study
- \*2 Consumer Patterns of the Aged, 1950-60

## Tennessee

- 1 Comprehensive Injury Control Program
- \*2 Retainer Payment for Physicians' Services

## Texas

- 1 Determinants of Health Services
- 2 The Adjustments Necessary in Small Hospitals and Nursing Homes Accounting Systems Under Medicare
- 3 A Pilot Methodological Study of the Cost of Debilitating Conditions in Areas of Poor and Overcrowded Housing

## Utah

- 1 Benefit Rating Program
- 2 Interpersonal Relationship in Rehabilitation
- 3 Assessment of Community Health Services; Salt Lake County, Utah

## Virginia

- 1 Evaluation and Improvement of Home Care Program, Richmond, Virginia

## Washington

- 1 Descriptive Analysis of Washington State Classification System for Nursing Homes and Nursing Home Patients
- \*2 Study of Costs and Patient Characteristics in Proprietary Nursing Homes
- 3 Cost of Mental Health Care Under Changing Treatment Methods
- 4 Prepayment of Drug Costs Under a Group Practice Prepayment Plan

## West Virginia

- 1 Health Facility Utilization by People Living in West Virginia Hollows

## Wisconsin

- 1 Health Data Resource Study
- 2 Health Service Data of Wisconsin, Inc.
- 3 A Socio-Professional Characterization of the Prescription-Compounding Function
- 4 Analysis of the Nursing Home Benefits of Medicare on the Nursing Homes of Wisconsin
- 5 Study of Organization of Pediatric Ambulatory Services for Patient Care and Teaching

## APPENDIX : STUDY GROUPINGS

## ALABAMA

1. PREPAYMENT OF DENTAL CARE IN  
A STUDENT HEALTH PROGRAM  
(Progress Report)

## Conducted by

George Mitchell, D.M.D., M.P.H.; James Ake; and Walter Pelton, D.D.S., M.S.P.H.  
for Public Health Service and University of Alabama Medical Center.

## Description

A description of an automated system for processing statistical data in Dental Prepayment programs. Overall project is long-term and continuing.

## Availability of Findings

Alabama Journal of Medical Services, Vol. 4, No. 3, July, 1967, p. 302.

## CALIFORNIA

1. DEVELOPMENT OF AN AUTOMATED DATA RETRIEVAL SYSTEM FOR  
UTILIZATION REVIEW AND SCHEDULING HOSPITAL ADMISSIONS

## Conducted by

U.S. Public Health Service—Institute of Medical Sciences Pacific Medical Center,  
San Francisco, California; by Charles P. Lebo, M.D.

## Problem

To develop a flexible replicable system of data collection on patients and beds, to provide major assistance in solving problems of inappropriate and poorly coordinated use of facilities and supply current and complete information for review of utilization in a single facility or on a community-wide basis.

## Methods

The system has been designed to permit efficient scheduling of admissions and surgery and a rapid, comprehensive method of utilization review at the lowest possible cost. Terminals have been installed at all nursing stations, the operating room, the admission desk, and the administrative departments of a representative general hospital. These terminals are connected to a PDP-8 data processor, which communicates with a remote time-shared computer facility. In addition to the scheduling of reservations and generation of utilization reports, the system also generates operating schedules and various administrative reports.

## Findings

Documentation of Phases I and II of ARBUS is nearing completion. The operational experience has been favorable. The system (known by the acronym ARBUS) has been well accepted by the medical community, and is now in a stage of expansion.

## Availability of Findings

For copies of the descriptive monograph write: The Department of Health, Education and Welfare, Division of Medical Care Administration, Public Health Service, 800 North Quincy Street, Arlington, Virginia 22203.

2. THE MULTITEST LABORATORY IN HEALTH CARE OF THE FUTURE  
(Progress Report)

## Conducted by

Kaiser-Permanente Medical Care Program; by Morris F. Collen, M.D.

## Problem

This Program utilizes an Automated Multiphasic Screening Project to investigate preventive medical methods for more effective detection, prevention, and control of chronic disease and disability, and to conduct epidemiologic research.

## Methods

The Program is evaluating multiphasic screening as part of periodic health examination as to its effectiveness in prevention of illness, and in reduction of morbidity

and mortality. Patients who are found to have abnormal tests are investigated by spin-off studies to determine the effectiveness of early treatment directed to postponing or preventing overt illness and disability.

### 3. IMPROVED NURSING CARE FOR THE GERIATRIC PATIENT

(Progress Report)

Conducted by

San Diego State College Foundation, Nursing Department; by Dorothy V. Moses, Professor of Nursing

Problem

- (a) What are the present curricula patterns in the teaching of geriatric nursing in collegiate programs?
- (b) Attitudes of nursing students towards various specialty areas within nursing.
- (c) Attitudes of Registered Nurses towards their work-role in Nursing Homes and Long-Term Care Facilities.
- (d) Analysis of situations with geriatric patients that nursing students and graduate nurses perceive as problems.

Methods

A, b, c are being investigated by questionnaire and coded by IBM machine. D— Over 200 narrative descriptions of actual situations as reported by students and staff nurses have been collected. These are being categorized and analyzed for basic knowledge that should be included in the curriculum to give information necessary for handling these kinds of situations. The attitude study of student nurses is being repeated annually in an attempt to measure changes that take place as the student progresses in the nursing program.

Availability of Findings

Partial findings will soon be published in NURSING OUTLOOK. Other findings will also be published.

### 4. PATTERN VARIATIONS IN PROVISION OF OUT-OF-HOSPITAL MEDICAL CARE

(Progress Report)

Conducted by

Committee on Health Economics and Administration, Institute of Business and Economic Research, University of California, Berkeley, California

Methods

Purpose is to examine the pattern variations among various methods of providing out-of-hospital medical care.

- (1) Analysis of numbers and types of medical care services, including diagnostic or therapeutic procedures and drugs provided by physicians.
- (2) Effects of physician and patient characteristics on the pattern of care provided.
- (3) Feasibility of using automated methods for continuous analysis of medical services.

### 5. STUDY OF HOME NURSING SERVICES IN CALIFORNIA

(Progress Report)

Conducted by

California State Department of Public Health  
Bureau of Chronic Diseases; by Lois C. Lillick, M.D.

Problem

Obtain descriptive data on patients served, types and kinds of service given and outcome of cases by home nursing programs in California to

- (1) use as a baseline in planning future home care programs and
- (2) improve the services given by these agencies.

**Methods**

Thirty-five home care agencies participated. Each new admission to the agency for therapeutic nursing between September 1, 1965, and February 28, 1966, was included. An admission and discharge form was completed on each patient. Information collected included: descriptive data on patient, the primary condition which brought the patient to service, who requested service, where patient resided at time of request, amount and kind of service received, evaluation of patient's condition.

**6. HOSPITAL-HEALTH DEPARTMENT RELATIONSHIPS AND THEIR EFFECTS****Conducted by**

Daniel M. Anzel, M.P.H., D.P.H.

**Problem**

Study of preventive health services, personal medical care services, and extra-mural health services in county and voluntary hospitals and their relationships with local health departments and the latter's influence on the county and voluntary hospitals' delivery of these services.

**Methods**

Conducted 1965-66 study of counties in California where the county health officer operates the county hospital. Study of eight counties with no joint administration. Study of four voluntary hospitals not affiliated with county health departments. Case studies.

**Findings**

In jointly administered counties, medical services of the county hospital were infused with preventive and rehabilitative content. However, similar findings were made at the separately administered county hospitals and also in the voluntary hospitals.

**Availability of Findings**

University Microfilms, Inc., Ann Arbor, Michigan.

**7. A STUDY OF THE REGIONALIZATION PROGRAM OF NAPA****STATE HOSPITAL****Conducted by**

Napa State Hospital, Imola, California. Investigation supported in part by research grant #66-10-25 from the California State Department of Mental Hygiene; by Irving Babow, Ph.D., Research Social Scientist.

**Problem**

To determine staff members' attitudes toward the introduction of a major administrative change, regionalization of a state mental hospital and toward attitudes which might be related to this innovation. Also, to provide baseline data for follow-up study at this institution and for comparative study at another state mental hospital.

**Methods**

A questionnaire was prepared including items on regionalization and items selected from the F-Scale on authoritarianism, Srole's anomia scale, and the Strauss-Schatzmann scales on treatment ideology and distributed to all staff members engaged in direct patient care or supervising such employees. Usable forms from 856 employees (73%) were submitted to factor analysis. Inter-correlations were ascertained between attitudes towards regionalization and the other sub-scales in the study, and attitude profiles were obtained in terms of primary clusters.

**Findings**

Factor analysis of staff attitudes toward regionalization of a state mental hospital resulted in a unidimensional factor structure heavily loaded in terms of administrative aspects of the change. A significant correlation of favorable attitudes on regionalization with a sociotherapeutic orientation was composed predominantly of staff members more distant from patient care and not in a position to effect change either in patient care in the ward or in the hospital administrative structure, even though these employees were highly motivated for change. Eighty-seven per cent of

response in this study was from nursing service. In planning major innovations in treatment programs, the success of and enthusiasm for the innovation by the nursing service seems highly dependent on the adequate resolution of problems of role conflicts and professional identity, both within the nursing profession and between nursing service and other health professionals.

#### Availability of Findings

I. Babow's and A. Johnson's *Report on Regionalization at a State Mental Hospital*, is available from the Research Department, Napa State Hospital, Imola, California

Other publications, in press, by Babow and Johnson:

- 1) "Staff Attitude Profiles and Response to an Administrative Innovation in a Mental Hospital," *Nursing Research*.
- 2) "Staff Attitudes Toward the Introduction of Regionalization at a State Mental Hospital," *Hospital and Community Psychiatry*.

### 8. HIGHLIGHTS OF HOSPITAL USE IN CALIFORNIA

#### Conducted by

Public Health Service research grant #HM-00194, Hospital Utilization Research Project, State of California Department of Public Health; by Irene Reed, M.P.H., Health Program Adviser.

#### Problem

Primarily to reveal trends in utilization among short term general hospitals in California. Also to provide a basis for comparing two major sources of information (i.e., Guide Issue of American Hospital Association and the California State Plan for Hospitals).

#### Methods

Methodological investigation of short term general hospital utilization with selected patient information (admissions, patient days) and selected hospital data (number of acute beds, average length of patient stay, occupancy rates) to ascertain value of this information and its reliability.

#### Findings

A need for a consistent set of definitions for reporting utilization data. Current reporting by hospitals does not give complete and comparable information.

#### Availability of Findings

"Highlights of Hospital Use in California," *Hospital Forum*, Part I, January 1967, Part II, February 1967, Vol. IX, Number 11.

### 9. THE IMPACT OF HEALTH INSURANCE COVERAGE ON HEALTH CARE OF SCHOOL CHILDREN

#### Conducted by

University of Southern California, School of Medicine  
University of California, Los Angeles, School of Public Health;  
by Joy G. Cauffman, Ph.D., et al.

#### Problem

- (a) Children whose families have health insurance are more likely to receive professional care than are children whose families do not have health insurance.
- (b) Children whose families belong to a health insurance plan which has commercial sponsorship are less likely to receive attention than are children whose families belong to a health insurance plan with provider or consumer/employer sponsorship.

#### Methods

Sample included Los Angeles City Schools District; 8 study areas within the District representing both high and low social ranks; 4th graders in 48 schools; health defects were identified through dental, otological, and general examinations administered by dentists, otologists, and other physicians during the 1963-64 school years; all children with medical or a combination of medical and dental defects



entered the sample; 20% of the children with only dental defects were selected by use of a systematic sampling technique; and data regarding 458 fourth grade children with health defects (92.5% of the sample) were used. Data included nature and disposition of the child's health problem (pupil health records), family background characteristics and health insurance information (parent interviews). Analysis was by Chi Square.

#### Findings

Children from insured families were more likely to receive care for their defects than were children from noninsured families. The probability of receiving care for school-detected defects, however, was not affected by categories of health insurance coverage (type of sponsorship and mode of practice).

#### Availability of Findings

Cauffman, Joy G., Roemer, Milton I. and Shultz, Carl S. "The Impact of Health Insurance Coverage on Health Care of School Children," *Public Health Reports*, 57: 60-73, January, 1967.

Cauffman, Joy G., et. al. "Impact of Health Insurance Coverage on Health Care of School Children," *Pediatrics Digest*, 9:23, September, 1967. (Abstr.)

### 10. VARIATIONS IN PATIENTS' COMPLIANCE WITH DOCTORS' ORDERS

#### Conducted by

Supported by a U. S. Public Health Service Program Grant (CH 00103-01), awarded to George G. Reader, M.D., Cornell University Medical College.

#### Problem

The extent and types of noncompliance of patients with doctors' advice, and the social, psychological and physiologic factors which might help explain why patients do not accept medical recommendations. More specifically, the following sets of variables were considered: (1) characteristics of patients, (2) types of medical advice, (3) interpersonal influences of family and friends and, (4) the structure and process of the doctor-patient relationship.

#### Methods

The study group consists of 154 new patients seen by 77 junior physicians (fourth year medical students) and 77 senior physicians (attending staff) and their patients in a general medical clinic. Over a period of 8 months tape recordings of doctor-patient visits were collected and analyzed. In addition patients were interviewed and doctors received questionnaires at different stages of illness. Finally, a content analysis of the patients' medical records was completed.

#### Findings

Thirty-seven per cent of the patient group disregarded what their doctors advised. Of this group 40 per cent admitted that they had no intention of complying prior to seeing the doctor. The data give empirical reason to reject all demographic variables as having any influence on patients' intended or actual compliance. When physiologic variables were examined, opposite to what might be expected patients with more severe ailments were somewhat less likely to follow doctors' advice. Those with the greatest disability were found to be less willing and less likely to follow doctors' orders. While sociomedical attitudes were not significantly related to compliance, the data lend an empirical base for patient personality types which are associated with normative and deviant patient roles. With regard to interpersonal influences, it was found that patients may be influenced by friends and relatives to initiate medical contacts and try home remedies; however, they have little impact on patients' compliance. While the doctor and patient exhibit normative behavior in the first visit, their second contact is more characterized by deviant behavior. Deviant communication in the interaction is significantly related to the patient's deviant, or non-compliant behavior once outside the doctor's office.

#### Availability of Findings

Attitudinal and Behavioral Aspects of the Doctor-Patient relationship as Expressed and Exhibited by Medical Students and their Mentors. *Journal of Medical Education*, (forthcoming, March, 1968).

Compliance with Medical Regimens: A Panel Study. *Journal of Health and Human Behavior*, 4:240-249, 1964.

Variations in Patients' Compliance with Doctors' Orders: An Empirical Analysis of Patterns of Communication. *Journal of the American Public Health Association*, February, 1968.

Variations in Patients' Compliance with Doctors' Orders: Analysis of Congruence Between Survey Responses and Results of Empirical Investigations. *Journal of Medical Education*, 41:1037-1948, 1966.

Predicting Noncompliant Behavior. *Journal of Health and Social Behavior*, 8:265-271, 1967.

Physiological, Psychologic and Demographic Factors in Patient Compliance with Doctors' Orders. *Medical Care*, (forthcoming.)

Variations in Patients' Compliance with Doctors' Advice: Deviant Interaction in an Institutionalized Relationship. *Transaction of Sixth World Congress of Sociology*, 1966.

#### 11. AVAILABILITY AND USEFULNESS OF SELECTED HEALTH AND SOCIO-ECONOMIC DATA FOR COMMUNITY PLANNING

##### Conducted by

Division of Maternal and Child Health, University of California, School of Public Health, Berkeley, California 94720; by Victor Eisner, M.D.

##### Problem

What readily available health and socio-economic indices are most useful for identifying multi-problem high-risk areas.

##### Methods

Twenty health indices and nine socio-economic indices for census tracts in San Francisco were studied. Eight health indices and seven socio-economic indices proved readily available. "Usefulness" was judged by map study and by factor analysis of correlations between indices.

##### Findings

Inadequate prenatal care, fetal mortality, incidence of prematurity, and incidence of tuberculosis were the most useful health indices. Low-income, inadequate education, unemployment, overcrowding, parental composition, school-age illegitimacy and juvenile delinquency were the most useful socio-economic indices. Four of these indices are available in intercensal years: inadequate prenatal care, fetal mortality, incidence of prematurity, and school-age illegitimacy.

##### Availability of Findings

Published in *American Journal of Public Health*, 57:762-771:1957. Reprints available from authors.

#### 12. STUDY OF A NEW APPROACH TO A MEDICAL COST INDEX

##### Conducted by

Division of Community Health Services, U. S. Public Health Service; and Palo Alto Medical Research Foundation, Palo Alto, California; by Mrs. Anne A. Scitovsky, Research Associate.

##### Problem

- (a) To explore feasibility of a medical care price index based on average costs of treatment of specific illnesses rather than on the prices of selected items of medical care as is BLS medical care price index;
- (b) If feasible, to estimate average costs of treatment of a number of illnesses in two different periods and to compare their cost changes with the price changes indicated by the BLS medical care price index over the same period.

##### Methods

The population studied consisted of patients treated on a fee-for-service basis by physicians of the Palo Alto Medical Clinic (PAMC), a multi-specialty group practice of about 100 physicians, in 1951-52 and 1964-65. The illnesses selected for study were: acute appendicitis, otitis media in children, maternity care, fracture of the

forearm (also in children only), and cancer of the breast. Data on treatment and costs were obtained from the medical histories and financial records of the PAMC and of the Palo Alto-Stanford Hospital where patients of PAMC physicians are treated when they need hospitalization; for 1964/65, some data were also obtained from the patients themselves who were contacted by questionnaire.

**Findings**

We found that, by and large, the cost-per-episode-of-illness approach was feasible, although some illnesses lend themselves better to it than others. We also found that in the 14 years from 1951/52 to 1964/65, the costs of treatment of all five illnesses (with one minor exception) increased more than the BLS medical care price index. The medical care price index for the United States as a whole rose by 55 to 59 per cent during this period (55% for 1964, 59% for 1965). By contrast, we found the following increases:

Acute appendicitis	87%	Fracture of the forearm:	
Otitis media in children	68%	Splint only	75%
Maternity care	72%	Cast only	55%
Cancer of the breast	106%	Closed reduction, local or no anesthetic	87%
		Closed reduction, general anesthetic	315%

While some of the differences between our indexes and the BLS index can be explained by the fact that our cost figures take account of some factors affecting costs which the BLS index does not take account of, notably changes in treatment, the increased use of specialists, inclusion in our data of some services not priced separately in the BLS index, and our use of average rather than customary physician fees, we are inclined to conclude that the BLS medical care price index has underestimated the increase in medical care costs in the period 1951 to 1965.

**Availability of Findings**

Major findings published in the December, 1967 issue of the *American Economic Review* under the title "Changes in the Costs of Treatment of Selected Illnesses, 1951-65." The full report is available upon request from the Palo Alto Medical Research Foundation, 860 Bryant Street, Palo Alto, California 94301.

**13. PSYCHIATRIC INSURANCE FOR WORKERS IN MANUFACTURING INDUSTRY**

**Conducted by**

National Institute of Mental Health Contract with the University of California.

**Problem**

Extent of coverage in industry for psychiatric disorders; utilization of these benefits; proneness to abuse; identification of high utilizers; trends in coverage and utilization of psychiatric services.

**Methods**

Interviews with medical directors of companies, insurance company executives, officials of Blue Cross and Blue Shield Plans and independent medical prepayment plans, questionnaires to 100 largest companies, nearly 300 local and national unions, to all U. S. Blue Cross and Blue Shield Plans. Communication with major independent prepayment plans, Veterans Administration, and California State Compensation Fund.

**Findings**

Coverage of blue collar workers precedes coverage for white collar workers. Information on utilization not available by insured groups generally, and high utilizers can only be identified impressionistically. The trend is to increased and more flexible mental health benefits. The Federal Employees Health Benefits Plan and the Agreements of The United Auto Workers have had marked influence in promoting broader psychiatric benefits. Tendency to offer more mental health benefits on basic contracts. More mental health benefits offered by independent plans. More use of community mental health centers.

**Availability of Findings**

National Institute of Mental Health, Community Services Branch, Bethesda, Maryland.

14. THE SOCIAL AND ECONOMIC PROBLEMS OF  
HEMODIALYSIS TREATMENT FOR CHRONIC RENAL FAILURE

Conducted by

Sponsored by Kidney Disease Branch, U.S. P.H.S.; conducted by UCLA School of Public Health; by Alfred H. Katz, Principal Investigator.

Problem

Social-demographic characteristics of patients on chronic hemodialysis treatment. Socio-psychological adjustment and rehabilitation status of such patients. Patient selection procedures in treatment centers.

Methods

Total population survey, all such patients in U.S. centers (800 patients-120 centers). Three questionnaires, source of basic data.

Availability of Findings

Findings available after July, 1968, from Kidney Disease Branch, U. S. Public Health Service.

15. DETERMINANTS OF THE USE OF  
AMBULATORY MEDICAL SERVICES BY AN AGED POPULATION

Conducted by

UGPHS Heart Disease Control Program; UCLA School of Public Health. Persons conducting study: Nancy J. Gaspard, Dr. P.H. and Carl E. Hopkins, Ph.D.

Problem

Hypothesis: When medical care is freely accessible, the amount of medical services consumed is determined by the objective disease.

Methods

USPHS Heart Disease Control Program established follow-up panel of 2000 residents, randomly selected from the community total of 10,000. Of these, 343 were between ages 65-69. A count was made of their use of medical service during the previous year. This count of use was taken as the criterion, and the 100 highest and 100 lowest on this variable, were selected as the study groups. Data on 265 variables presumed to be related to amount of use of medical services were obtained by: medical record review; a self-administered symptom check-list; a personal interview; and a clinical evaluation of functional capacity. The multiple linear regression model was used for the purpose of examining the association of the "predicting" variables, singly, and in combination with, level of use.

Findings

Level of use was found to be related primarily to objective (mostly chronic) disease in the population, and not significantly related to socio-psychological factors such as hypochondria, loneliness, or anxiety. Self-estimates of their health status by the subjects tended to be corroborated by physicians' diagnosis. No evidence was found of high demands not associated with objective illness. Socio-psychological factors had only indirect relation to demands for service. Among the low users, unmet medical needs were accurately reflected in their symptoms, their anxiety, and their low self-estimates of health status.

Availability of Findings

Gaspard, Nancy J. "Determinants of Use of Ambulatory Medical Services by an Aged Population," Doctoral Dissertation, UCLA, 1966. Gaspard, Nancy J. and Carl E. Hopkins. "Determinants of Use of Ambulatory Medical Services by an Aged Population," *Inquiry*, March, 1967, Vol. IV, No. 1, p. 28.

16. DEMONSTRATION OF A STATE INFORMATION SYSTEM FOR  
HEALTH FACILITIES PLANNING (CHIPS PROJECT)

Conducted by

California Health Information for Planning Service, under the sponsorship of the

State Department of Public Health, (USPHS grant-HM00446); by J. W. Lubin, M.C.P., et al.

#### Problem

- (1) To identify data needed by user organizations for health facilities planning and related functions of institutions operations and licensing requirements.
- (2) To select the best sources for providing the pertinent data.
- (3) To test methods for collection, storage, and retrieval of the data.
- (4) To evaluate the system for statewide services.

#### Methods

The purpose of the project was to demonstrate an information system. Santa Clara County, California, was the test site for certain portions of the project.

#### Findings

CHIPS demonstrated that good planning information can be obtained as a by-product of the ongoing services required by health agencies and facilities. A statewide health information system is both desirable and feasible; but the most likely means of implementing such a system is by a statewide health information exchange based on local computing centers.

#### Availability of Findings

Summary Report will be available about May, 1968. Also, *An Information System for Health Facilities Planning*, 95th Annual Meeting of APHA.

### 17. HEALTH CARE PLANS UNDER COLLECTIVE BARGAINING: CALIFORNIA

#### Conducted by

California Department of Industrial Relations, Division of Labor Statistics and Research.

#### Problem

Health Care Plans under Collective Bargaining.

#### Methods

Analysis of union contracts in California covering 1,000 or more workers.

#### Findings

Most (97%) of all California workers under union contract were covered by health and welfare plans providing hospital, surgical, and medical benefits at employers' expense. About 1/3 also received major medical coverage. Full cost of basic plan paid by employer in 74% of plans; employee coverage only paid in 14% of plans; partial payment of employee coverage in 12% of plans. The majority of plans were underwritten by insurance companies, with Blue Cross accounting for next largest insurer, and Kaiser Foundation for the next. In 80% of the plans, surgery benefits were provided for on a schedule of dollar allowances. There was a wide variance of "renewal of benefits" clauses. Most plans offered workers some medical benefits, while few covered benefits for dependents. A two-visit waiting period for office and home visits was found to be fairly standard, while there was wide variance in the benefit allowances for physician visits. The majority of plans specified a dollar allowance for office visits; about 15% of workers had coverage which provided full service benefits for office visits. Home visits were most commonly provided for at \$6 per visit; very few plans provided full coverage for home visits.

#### Availability of Findings

California Department of Industrial Relations. Division of Labor Statistics and Research.

### 18. COHORT ANALYSIS OF ADMISSIONS TO STOCKTON STATE HOSPITAL FOR FISCAL YEAR 1955-56

#### Conducted by

Department of Mental Hygiene, Research Department, Stockton State Hospital; by Robert L. Griswold, M.D.

**Problem**

A detailed analysis of a cohort of admissions to one hospital during a period of one year.

**Methods**

- (1) Coded Punch Cards for all admitted, individual's descriptive characteristics.
- (2) 2,206 patients selected categorized into 5 types:
  - (1) Resident in hospital
  - (2) Released on indefinite leave of absence
  - (3) Discharged
  - (4) Unauthorized absence
  - (5) Dead
- (3) Cohort consisted of only newly admitted patients.
- (4) Design to dissecting out the various influences which determine the composition of a population of patients admitted to a State Hospital.

**Findings**

- (1) 9.9% Mortality while on hospital record during 3 years the cohort was followed.
- (2) 75% of total was back in the community either by discharge, leave of absence, or unauthorized absence.
- (3) Slow progress of release curve after one year, with voluntary patients showing a slower rate of release.
- (4) Race seems to have no affect on release ratio for males. In females the results are better for Negroes than for whites.

**Availability of Findings**

- (1) Epstein, L. J., and Morgan, R. D. Trends in Release Rates of Schizophrenic Patients. *Comprehensive Psychiatry* 2:196-202, 1961.
- (2) Lehrman, N. S. A State Hospital Population 5 Years After Admission: A Yardstick for Evaluative Comparison of Follow-Up Studies. *Psychiatric Quarterly* 34: 658-681, 1960.

**19. RECENT CHANGES IN VOLUNTARY HEALTH INSURANCE COVERAGE****Conducted by**

Health Insurance Institute.

**Problem**

Changes in voluntary health insurance coverage in California and the United States.

**Methods**

Survey of existing health insurance plans.

**Findings**

As of 1965, more than four of five Americans had voluntary health insurance protection against hospitalization expenses, over three out of four against surgical expenses, nearly three in five against regular medical expenses, over one in four against major medical expenses and the same proportion against loss of income during periods of illness or injury. The figures demonstrate a continued trend of increases over the last several years with the most sizeable gains being made in major medical expense coverage. California also showed increases in health insurance coverage. The state ranked below the national average in per cents of the population covered for hospitalization and surgery, but was slightly ahead in regular medical expense coverage. Above-average progress has been made in increasing the extent of hospitalization coverage for Californians, while increases in other areas have been well below the national figures. Example: 67.7% of Californians have surgical coverage, while the comparable national figure is 75.7%.

This gap was greater in 1965 than it was in 1963. Note that the situation described is prior to the implementation of Medicare.

20. PSYCHIATRIC SERVICE AND MEDICAL UTILIZATION IN  
A PREPAID HEALTH PLAN SETTING, PART II

N. A. Cummings, Ph.D., and W. T. Follette, M.D.

Conducted by

Kaiser Foundation Research Institute and the United States Public Health Service  
(Contract PH 108-66-235).

Problem

The effect of utilization of psychiatric services of early detection and referral of emotional problems in general medical patients in a health plan setting.

Methods

Over a year a concerted attempt was made to increase the psychotherapy utilization of 10,667 medical patients by early detection of emotional problems through an automated health screening to which all patients had voluntarily submitted as part of their general health care. Emotional problems were identified and followed by vigorous physician referral to psychiatry.

Findings

Attempts at early detection and referral of emotional problems did not generate more psychiatric clinic patients than those generated through routine medical practice in this setting. There was resistance from both patients and physicians to being manipulated in the matter of health care. It was concluded that when psychotherapy is a long-standing provision in comprehensive health care, attempts to increase utilization do not disturb the relative stability of the utilization of psychiatric services.

Availability of Findings

Published: *Medical Care*, Volume 6, Number 1, January-February, 1968.

21. EVALUATION OF OUT-OF-HOSPITAL MEDICAL CARE FOR THE  
INDIGENT AGED

Conducted by

State of California, Office of Health Care Services; by Ronald P. Dowd, D.P.H.

Problem

To review medical care utilization among Old Age Security (PMAC) recipients in Los Angeles, and compare physicians providing service with those who did not.

Methods

- (1) Sample of 1014 OAS recipients for social, geographic, and medical care utilization information.
- (2) Separate collection of information on characteristics of physicians in Los Angeles County.

Findings

- (1) Surprisingly, utilization of the elderly was relatively lower.
- (2) Negroes had relatively high utilization rates.
- (3) A greater proportion of general practitioners vis-a-vis specialists participated in PMAC and general practitioners were more numerous among "high" providers of service.
- (4) Communities with lower socio-economic status had lower physician-population ratios, greater proportions of physicians participating in PMAC and higher average PMAC payments to physicians.

Availability of Findings

Two reports, published by sponsor:

(1) *Medical Care Utilization Among Recipients of Old Age Security*. Sacramento: Office of Health Care Services, 1968.

(2) *Characteristics of Physicians Serving Welfare Recipients in Los Angeles County*. Sacramento: Office of Health Care Services, 1968.

## 22. PARAMETERS OF DEMAND FOR PHYSICIANS

### Conducted by

Arnold I. Kisch, M.D.; Division of Medical Care, UCLA, School of Public Health.

### Problem

Parameters of demand for health care services and comparison of production functions for ambulatory care in the group practice and solo practice setting.

### Methods

Two defined populations are being studied; one insured under a comprehensive prepaid group practice plan and the other insured through a medical foundation health insurance plan. Data collected was by household interview and by review of patients' charts at the group practice and the medical foundation. A multiple regression technique will be used to analyze the data relating to demand. Direct observations will be the basis for the production functions to be developed.

### Findings

The principal findings of the study are not yet available. The study runs until August, 1969.

### Availability of Findings

The major publications of this research project are still being prepared.

## 23. CASE STUDIES OF ADMINISTRATIVE PRACTICES IN MEDICAL CARE SETTINGS

### Conducted by

Arthur E. Visel tear, A. I. Kisch, and Milton I. Roemer, M.D.; Division of Medical Care Administration, Public Health Service, Department of Health, Education and Welfare.

### Problem

Historical narratives of four medical care issues as follows:

- (1) the establishment of a prepaid, group practice clinic in Los Angeles;
- (2) the merger of Doctors of Medicine and Doctors of Osteopathy in California;
- (3) the establishment of a union-sponsored dental clinic; and
- (4) the establishment of a branch of the county hospital in a lower-socio-economic area of Los Angeles following a riot.

### Methods

Historical narrative based on primary reference material, such as letters, minutes, telegrams, memoranda, and interviews and secondary reference material, such as newspapers, texts, commission reports, and pamphlets.

### Findings

The case studies relate the complete story of the medical care issue — its conflict and resolution. The authors' narrative is then employed as a teaching device for students of medical care administration.

### Availability of Findings

The four studies prepared under contract have been published by the USPHS, and are readily available upon request: A. I. Kisch and A. J. Visel tear. "Doctors of Medicine and Doctors of Osteopathy in California; Two Separately Legitimized Medical Professions Face the Problem of Providing Medical Care." (Case Study No. 2, June 1967; pp. 1-44, plus appendices); "The Ross-Loos Medical Group; A comprehensive Prepaid Group Practice Establishes Itself in California." (Case Study No. 3, June 1967; pp. 1-37, plus appendices); "The Los Angeles Culinary Union Dental Clinic; A Labor-Management Welfare Fund Experiments with a



Dental Benefit." (Case Study No. 4, June 1967; pp. 1-39, plus appendices). A. J. Visellear, A. I. Kisch and Milton I. Roemer. "The Watts Hospital; A Health Facility is Planned for a Riot-Torn Metropolitan Slum Area." (Case Study No. 5 — in press).

24. HOSPITAL NURSES, SUPPLY AND DEMAND:  
A STUDY OF CHANGES IN SUPPLY OF AND DEMAND FOR  
HOSPITAL NURSES RELATIVE TO CHANGES IN NURSES WAGES, 1966-67,  
SAN FRANCISCO, CALIFORNIA, AND PHOENIX, ARIZONA

Conducted by

Donald M. DuBois, D.P.H.; General Research Support, USPHS, School of Public Health, UCLA.

Problem

What effect did changes in wages paid nurses have on supply and demand for hospital nurses? In economic terms, what does this data suggest about the labor market for hospital nurses?

Methods

Study of data gathered from a sample of hospitals in San Francisco and Phoenix. Data pertains to nursing employment patterns before and after wage adjustments and to the magnitude of those adjustments.

Findings

Being formulated.

Availability of Findings

To be made available about June 1, 1968.

25. PATTERNS OF MEDICAL CARE ORGANIZATION UNDER HEALTH  
INSURANCE: COMPARATIVE STUDIES

Conducted by

Sponsor: United States Public Health Service

Research Group: Division of Medical Care Organization, UCLA,  
School of Public Health (Dr. Milton I. Roemer, Chairman)

Problem

The research project is titled "Patterns of Medical Care Organization," and has as its goal the investigation of major types of health insurance plans in the Los Angeles area. For each plan, the organization, consumers and physicians are studied in order to explain variations in (1) cost, (2) utilization, (3) attitude and (4) quality of care.

Methods

Information on each of the three sectors mentioned in (2) above is gathered through mailed questionnaires and personal interviews. Data gathered is on a great range of variables within each sector, and analysis will relate these independent variables individually and in various combinations to the output or dependent variables. Information ranges from attitudinal, background and behavioral variables to structural variables of formal and informal organization.

Findings

Information from pretest studies is available indicating tentatively that (1) physician attitudes may lie along the sociological dimension of localism-cosmopolitanism, and that behavioral manifestations may also be significantly related to this concept; (2) consumer satisfaction with insurance and medical services may be explained through a complex model of variables ranging from the demographic to social and attitudinal. Models have been constructed, and will serve to guide the analysis of the study data when it is all collected.

Availability of Findings

(1) R. Sasuly and M. I. Roemer, "Health Insurance Patterns: A conceptualization

from the California Scene," *Journal of Health and Human Behavior*, 1966, 7/1 (36-44).

- (2) R. Sasuly and Carl E. Hopkins, "A Medical Society-sponsored Comprehensive Medical Care Plan: The Foundation for Medical Care of San Joaquin County, California," *Medical Care*, 1967, V/4 (234-248).

In addition, nine other papers have been written and are in various stages of readiness for publication. Preliminary copies are now available.

## 26. METHODS FOR ESTIMATING HOSPITAL BED NEEDS

### Conducted by

Joan R. Harris, M.A., and Carl E. Hopkins, Ph.D.; School of Public Health, University of California, Los Angeles, supported by the California State Department of Public Health.

### Problem

Predicting hospital bed needs as influenced by socio-economic and demographic variables.

### Methods

- (a) National Health Survey data measured against the characteristics of the population in hospital use, measured in patient days, in California.
- (b) Patient origin studies done in California.
- (c) Regression analysis of socio-economic variables on hospital use was done in the 58 counties of the State.
- (d) Review of consequences of the present State plan for deciding allocation of Hill-Harris funds.

### Availability of Findings

Bureau of Hospital Planning and Construction, State Department of Public Health, Berkeley, California.

## 27. GROUP MEDICAL PRACTICE, AN ANALYTICAL STUDY

### Conducted by

Donald M. DuBois, D.P.H.; School of Public Health, University of California, Los Angeles; supported by the National Advisory Commission on Health Manpower.

### Problem

What is known about group medical practice which has implications for dealing with the health manpower shortage.

### Methods

An integration of the most significant items of knowledge about group medical practice.

### Findings

Group medical practice is potentially both more efficient and more effective as a delivery method for modern medical technology. The full potentialities of group medical practice are seldom if ever achieved, however, due to the social and economic structure of medicine. To make full use of the potential economies and efficiencies of group practice it would be necessary to create a social and economic environment for medical practice in which creation or preservation of health, rather than the treatment of illness, is the primary objective.

### Availability of Findings

Unknown at this moment. Report is the property of National Advisory Commission on Health Manpower.

28. INVENTORY OF POSITIONS IN MEDICAL CARE ADMINISTRATION AND  
POTENTIAL PERSONNEL REQUIREMENTS, LOS ANGELES,  
AND UNITED STATES

Conducted by

Milton I. Roemer, M.D., and Daniel M. Anzel; School of Public Health, University of California, Los Angeles, California.

Problem

Definition of the types of agency and types of position concerned with medical care administration, with quantification of the numbers of administrative positions of different types that exist in the United States.

Methods

Three phases:

- (1) A questionnaire survey of the members of the Medical Care Section, American Public Health Association,
- (2) Personal interviews in a sample of about 600 agencies of 40 categorical types in the Los Angeles metropolitan area. The interview schedule solicits details on administrative job functions in each agency,
- (3) Interpolation of local findings, with adjustments, to the U.S. national situation.

Findings

Very heterogeneous spectrum of positions concerned with administration of various aspects of medical care delivery, quality supervision, planning, etc. Quantitative findings not yet available except for Phase 1.

Availability of Findings

Milton I. Roemer and Daniel M. Anzel, "Medical Care Administrative Positions in the United States," *Medical Care*, Vol. VI, No. 1, January-February, 1968, pp. 78-85.

Former publication in this field of study:

Milton I. Roemer, "Medical Care Administration in the United States: Personnel Needs and Goals," *American Journal of Public Health*, Vol. 52, No. 1, January, 1962, pp. 8-17.

29. AN EVALUATION OF ALTERNATIVE METHODS OF  
ESTIMATING PHYSICIANS' EXPENSES RELATIVE TO OUTPUT

Conducted by

Human Resources Research Center, Research Institute for Business and Economics, University of Southern California.

Problem

Are costs of providing physician services subject to economies of scale; if so, to what extent.

Methods

Data was collected by Medical Economics, Inc., 1965, at which time physicians were chosen at random from AMA list of self-employed physicians. Questionnaires were sent and the final sample consisted of data from 1,262 of these. Analysis was made using a linear, stepwise, least squares, multivariate regression program (significance at .01 level).

Findings

There is strong evidence to support the intuitive belief that physician's expenses are subject to economies of scale. However, three strikingly different models of the physician's expense function give equally good fits. More work is being done in this area.

Availability of Findings

*Inquiry*, Volume IV, No. 1, March, 1967.

## COLORADO

1. A NEW TRAINING PROGRAM FOR NURSES WHICH WILL PREPARE THEM  
TO GIVE IMPROVED HEALTH CARE TO CHILDREN IN  
MEDICALLY DEPRESSED AREAS

## Conducted by

H. K. Silver, M.D., et al.; Department of Pediatrics, University of Colorado School of Medicine; and University of Colorado School of Nursing.

## Problem

The establishment and evaluation of a new educational and training program in pediatrics for professional nurses (the "pediatric nurse practitioner program") to assume an expanded role in child health in the offices of private pediatricians and in health stations in low-income areas.

## Methods

Nurses receive a four-month training period here at the Medical Center and then serve in pediatricians' offices (principally with middle-and-upper-class patients) and in health stations with low-income patients.

## Findings

In field stations, pediatric nurse practitioners can provide almost total care to well children and manage over 50% of the problems of the sick and injured.

## Availability of Findings

(a) "A Program to Increase Health Care for Children: The Pediatric Nurse Practitioner Program." Silver, H. K., Ford, L. C., and Stearly, S. G., *Pediatrics*, 39:756, 1967. (b) "The Pediatric Nurse Practitioner at Colorado." Silver, H. K., and Ford, L. C. *American Journal of Nursing*, 67:1443, 1967. (c) "The Pediatric Nurse Practitioner Program." Silver, H. K., Ford, L. C., and Day, L. R. *J.A.M.A.* (in press).

2. EVALUATING THE QUALITY OF  
PATIENT CARE IN A PEDIATRIC EMERGENCY ROOM

## Conducted by

Ray E. Helfer, M.D., University of Colorado Medical Center.

## Problem

A method for assessment of clinical judgment making.

## Methods

Two pediatric interns' charts involving complaints of cough, cold or fever were reviewed without their knowledge and the following measures were calculated: Proficiency Index — (number of essential items recorded ÷ total number of essential items × 100); Efficiency Index — (total number of helpful items ÷ total number of recorded items × 100); and Competency Index — (PI × EI/100) ÷ PI. Also, the number of throat cultures taken was tabulated and a critical evaluation made of the appropriateness of the diagnosis treatment and disposition.

## Availability of Findings

*Journal of Medical Education*, Vol. 42, March, 1967.

## CONNECTICUT

1. A SYSTEM OF RECORDS AND STATISTICS FOR OUT-PATIENT CLINICS  
AS A BASIS FOR ADMINISTRATION AND RESEARCH

## Conducted by

E. R. Weisnerman, M.D.; Office of Ambulatory Services, Yale-New Haven Hospital and Department of Epidemiology and Public Health, Yale University School of Medicine.

## Problem

Design and testing of a system for the collection and analysis of data on personal

characteristics, rates of utilization of services, cost of services, attitudes of patients and selected aspects of clinical information regarding out-patient services in hospitals and independent clinics.

#### Methods

Design and "field" testing of data collection forms; installation of new system in selected clinics of two hospitals; trial runs and demonstration analyses of sample data collected, using the existing hospital computer equipment.

#### Findings

A descriptive document has been produced, presenting the data collection and analysis system, including definitions, explanations and discussion of administrative and research applications.

#### Availability of Findings

As the result of a contract for such work, this final report is now the property of the division of Medical Care Administration of the Public Health Service. Requests for copies should be addressed to Mrs. Beverlee Myers of that office.

## 2. HEALTH INSURANCE THROUGH COLLECTIVE BARGAINING IN THE NEW HAVEN AREA

#### Conducted by

I. S. Falk; Department of Epidemiology and Public Health, Yale School of Medicine in collaboration with the Health Committee, Greater New Haven Central Labor Council; (supported by a research program support grant, PHS).

#### Problem

Prevalence, content, cost and effectiveness of health insurance through collective bargaining in an urban area.

#### Methods

Survey of all labor unions in the (New Haven) area through a questionnaire, follow-up, and use of supplementary documental information; statistical coding and analysis.

#### Findings

Responses (nearly 100% coverage) show: widespread prevalence of health insurance benefits and distribution among diverse insurance carriers; financing is mainly through employer payments; heavy concentration on hospitalized illness; the benefits are mainly partial indemnity rather than service type; and, in the aggregate, the collectively-bargained group insurance contracts probably covered somewhat less than one-third of all private expenditures for personal health services.

#### Availability of Findings

Principal findings included in: "Health Insurance Through Collective Bargaining in an Urban Area," by I. S. Falk and Anita Pepper. *American Journal of Public Health*, 56:12, December, 1966, pages 2006-2022. (Reprint attached).

## 3. CONNECTICUT HOMEMAKER SERVICES COORDINATION-TRAINING, ASSISTANCE EVALUATION

#### Conducted by

H. S. Barrett, M.D.; Connecticut State Department of Health.

#### Problem

- a) How to organize local groups and communities to establish and provide sound homemaker services.
- b) How to standardize bookkeeping and costing of homemaker services.
- c) How to train homemakers.

#### Methods

Manuals were written on accounting and on training. Consultation of trained staff

was made available to communities, and subsidy on a five year decreasing basis was set up to stimulate the development of services.

#### Findings

- a) Methods of accounting were standardized and a manual finalized.
- b) Training was standardized and an additional grant requested which has led to the establishment of a permanent type of training approved by the Department of Health and conducted by the Department of Education in its Vocational Training Program.
- c) In the community development of services the number of agencies was doubled, the number of homemakers employed full time was increased by one-third and the number of part-time homemakers employed by one and a half times with the total number of homemakers employed doubled. The hours of service rendered were increased by 110%. Ten new services developing during the life of the project were assisted financially and by consultation representing one-third of all of the present services in the State of Connecticut.

#### Availability of Findings

Reprints are available from the Connecticut State Department of Health for as long as the supply lasts. Not all publications are still currently available.

#### 4. ELM HAVEN CONCERTED SERVICES HEALTH PROJECT

##### Conducted by

J. B. Atwater, M.D.; New Haven Health Department, New Haven, Connecticut.

##### Problem

Need for and methods of integrating health services into an intensive "concerted services" approach to meeting the social, educational, welfare and employment needs of the residents of a low and medium income public housing project.

##### Methods

Provision of traditional and new public health services to the project population by a team of public health nurses augmented by physicians, health aides and social workers. Special studies of health experiences, attitudes and needs were conducted as were various efforts to organize and involve the community in the provision of public health services.

#### Findings

- a) Health needs are generally met on a crisis basis and usually take second priority to other family needs.
- b) Participant conceptions of needed services were unrewarding with the exception of an expressed need for family planning aid.
- c) Use of indigenous non-professional staff was successfully explored.

#### Availability of Findings

Final report available from New Haven Health Department, One State Street, New Haven, Connecticut, entitled, "Report of a Health Project — A Three Year Demonstration, Elm Haven Health Services."

#### 5. THE DEVELOPMENT OF STANDARDS FOR THE AUDIT AND PLANNING OF MEDICAL CARE

(Progress Report)

##### Conducted by

H. K. Schonfeld and I. S. Falk; Department of Epidemiology and Public Health, Yale School of Medicine, supported in part by a grant from the Welfare and Social Security Administrations, U. S. Dept. of Health, Education and Welfare.

##### Problem

What, in the opinion of knowledgeable practitioners, constitutes good medical care. How this content can be used to describe the kinds and amounts of services needed for prevention, diagnosis, treatment and after-care, by what kinds of practitioners, where, when, under what circumstances and how much time is in-

volved. How these data can be used to prepare standards and indexes appropriate for measuring, describing and evaluating medical care (the audit process) and for the planning of care.

#### Methods

Based on data derived from the opinions of practitioners and others concerned in the provision of medical care. Initially, primary physicians — internists for adult care and pediatricians for the care of children — were interviewed on each of approximately 230 diseases and disorders by staff physicians using specially prepared questionnaires. In the second phase of the study, referral specialists, laboratory personnel and others are being interviewed. Data are being collected on approximately sixty diseases. In both phases, data are being collected with regard to the percentages of patients — disease by disease — according to the number, time and location of visits needed (including hospitalization) for diagnosis, treatment and follow-up; the number and kinds of diagnostic and follow-up procedures, and the time and kind of personnel needed to perform these procedures; the number and kinds of treatment procedures, and the time and personnel needed; the kinds of referral specialists needed and when; the kinds of auxiliary personnel required; the complications that may arise; the kinds of appliances needed and the factors that might interfere with the provision of good care. The data from the individual interviews are being summarized and presented in the form of mean, median, and range values and by distributions. Diagrammatic representations of the pathways of care are also developed. Where significant differences of opinions exist among interviewed physicians, these differences are being maintained. Where substantial agreement exists, the summarization statistics are being used.

#### Findings

Tentative tabulations indicate the feasibility of this approach. Pathways of medical care, which include the sequence of events, the kinds of practitioners providing these services, the kinds and amounts of services, and the time needed to provide these services are being prepared from the point of view of the primary physician as well as that of the referral specialist. Estimates of needed manpower are being prepared, using the standards developed from this study and incidence and prevalence rates obtained from published sources. Costs for services can be calculated by applying dollar values to the quantity of services recommended.

#### Availability of Findings

Several publications are available concerning this study. These are: a) Falk, I. S., Schonfeld, H. K., Harris, B. R., Landau, S. J., and Milles, S. S., *The Development of Standards for the Audit and Planning of Medical Care I. Concepts, Research Design, and the Content of Primary Physician's Care.* A.J.P.H. 57, 7:1118-1136 (July) 1967.

b) Schonfeld, H. K., Falk, I. S., Lavietes, P. H., Milles, S. S., and Landau, S. J., *The Development of Standards for the Audit and Planning of Medical Care: Pathways Among Primary Physicians and Specialists for Diagnosis and Treatment.* (To be published in *Medical Care*, Volume 6, No. 2, March-April 1968).

### 6. THE CONTENT OF GOOD DENTAL CARE: METHODOLOGY IN A FORMULATION FOR CLINICAL STANDARDS AND AUDITS, AND PRELIMINARY FINDINGS

(Progress Report)

#### Conducted by

H. K. Schonfeld and I. S. Falk; Department of Epidemiology and Public Health, Yale School of Medicine, supported by a grant from the Welfare and Social Security Administrations, U. S. Dept. of Health, Education, and Welfare.

#### Problem

What, in the opinion of knowledgeable dental practitioners, constitutes good dental care. How this content can be used to describe the kinds and amounts of services needed for prevention, diagnosis, treatment and after-care, by what kinds of practitioners, where, when, under what circumstances and how much time is involved. How these data can be used to prepare standards and indexes appropriate for measuring, describing and evaluating dental care (the audit process) and for the planning of care.

**Methods**

Based on data derived from the opinions of practitioners and others concerned in the provision of dental care. Initially, 7 general dental practitioners are being interviewed by staff dentists using specially prepared questionnaires. Data are being collected with regard to the percentages by patients — by type of dentition and prior care status — according to the number and time of visits and services needed for the prevention, diagnosis and treatment of each of a number of dental diseases, as well as for examination and treatment planning. The data from the individual interviews are being summarized and presented in the form of mean, median, and range values and by distributions. Where significant differences of opinions exist among interviewed dentists, these differences are being maintained. Where substantial agreement exists, the summarization statistics are being used. In subsequent stages of the study, specialists will be interviewed. Also, it is anticipated that the study will be expanded to include a larger number of dentists.

**Findings**

Tentative tabulations indicate the feasibility of this approach. Estimates of needed manpower are being prepared, using incidence and prevalence rates obtained from published sources. Costs for services can be calculated by applying dollar values to the quantity of services recommended.

**Availability of Findings**

Several publications are available concerning this study. These are:

- a) Schonfeld, H. K., Falk, I. S., Sleeper, H. R., and Johnston, W. D., The Content of Good Dental Care: Methodology in a Formulation for Clinical Standards and Audits, and Preliminary Findings. *A.J.P.H.* 57, 7:1137-1146, (July) 1967.
- b) Schonfeld, H. K., Falk, I. S., Sleeper, H. R., and Johnston, W. D., Professional Standards for the Content of Dental Examinations, paper presented at the annual meetings, American Dental Association, Washington, D. C., October 31, 1967. It is anticipated that other papers will be prepared, describing various aspects and findings of the study.

**7. A STUDY OF PATIENT CARE IN A GENERAL HOSPITAL****Conducted by**

R. S. Duff; Division of Nursing, Health, Education, and Welfare.

**Problem**

The human group and patient care focus is on many problems including physician, nurse, family influences; decision-making, cost, consequences for the patient, family, etc.

**Methods**

Controlled case study of 161 patients admitted to a general hospital.

**Findings**

The care of patients is confused and confusing. But there is hope, we think, for constructive changes in the future. Although decision-making and action-taking was not included as a major part of the study in relation to cost, several findings relate to these issues.

**Availability of Findings**

R. S. Duff and A. B. Hollingshead, *Sickness and Society*, in press, Harper and Rowe, for publication in May, 1968.

**8. DESIGN OF A COMMUNITY (GROUP PRACTICE) PROGRAM FOR  
COMPREHENSIVE FAMILY CARE IN ASSOCIATION WITH  
A TEACHING AND RESEARCH MEDICAL CENTER**

(Progress Report)

**Conducted by**

I. S. Falk; Department of Epidemiology and Public Health, Yale School of Medicine (supported by contract with the Division of Hospital and Medical Facilities, Bureau of Health Services, PHS).



**Problem**

Design of a plan for comprehensive family care through prepaid group practice in association with a medical school and teaching hospital; to serve the combined purposes of:

- a) Provision of comprehensive family care,
- b) Serving as a resource for education and training in a group practice setting, and
- c) Serving as a resource for clinical, epidemiological and administrative research.

**Methods**

Development of authorizing legislation; formation of a community non-profit corporation; cultivation of a subscriber population; affiliation with a teaching medical center; population (demographic) studies; estimates of medical services to be needed; staffing plans; design of a health center facility; arrangements for interlocking services in the health center and the teaching center; estimates of costs and prepayment; etc.

**Findings**

The authorizing legislation has been enacted; policy agreement for the affiliation with the teaching center has been formulated; and many special studies are still in progress on population characteristics, staffing needs; facility design, cost estimates, etc.

**Availability of Findings**

Findings and publications will probably be available in 1969.

**DISTRICT OF COLUMBIA****1. INTERNATIONAL COMPARISON OF PERINATAL AND INFANT MORTALITY:****THE UNITED STATES AND SIX WEST-EUROPEAN COUNTRIES****Conducted by**

H. C. Chase, D.P.H.; National Center for Health Statistics, U. S. Department of Health, Education, and Welfare.

**Problem**

Statistical comparison of infant mortality in the seven countries and some demographic, biological, and medical care correlates.

**Methods**

The study is based on independent reports of infant mortality for six of the seven countries. Trends are shown beginning with 1935 while diagnostic comparisons are for the period beginning with 1950. In addition to vital statistics, information is drawn from auxiliary sources and studies. The magnitude of the possible sources of bias in the vital statistics are considered.

**Findings**

Since 1950, infant mortality in the U. S. has no longer been declining at former pace. Among the 7 countries analyzed, the position of the infant mortality rate for the United States has changed: in 1950, it ranked in mid-position (4th), while in 1964, its rate was highest. The age period which was most resistant to change was the first 24 hours of life. While fetal mortality and mortality 1-6 days decreased 21 and 17 per cent respectively, between 1949-51 and 1959-61, mortality in the first 24 hours of life increased 2%. Factors such as mother's age and infant's birth order explain only a small portion of the difference between the U. S. and other countries. Birth weight, however, evolved as a variable requiring further study. Patterns of population utilization of medical care, and details of medical and obstetric care are difficult to assess because of the limited scope of comparable quantitative information.

**Availability of Findings**

Copies of "International Comparison of Perinatal and Infant Mortality: The United States and Six West-European Countries" (PHS Publication No. 1000, Series 3, No. 6), 97 pp. may be purchased for 70¢ from Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

## 2. COMPLEMENTARY COVERAGES TO MEDICARE

## Conducted by

Louis S. Reed; Office of Research and Statistics, Social Security Administration.

## Problem

Types of complementary coverage offered by the various types of carriers, extent of such coverage, cost, problems of coordination with Medicare, if any, etc.

## Methods

Obtained information sample contracts and policies, etc., from carriers in early 1967.

## Findings

Such coverages have been widely offered and sold. They are of many different types.

## Availability of Findings

Article published in August, 1968, Social Security Bulletin. A more extensive report may be published later.

## 3. SELECTED DATA ON GROUP PRACTICE PREPAYMENT PLAN SERVICES

## Conducted by

Group Health Association of America, Inc.

## Problem

Utilization and costs under Prepaid Group Practice.

## Methods

Comparative statistical analysis.

## Availability of Findings

a) *Selected Data on Group Practice Prepayment Plan Services* by Jocelyn Chamberlain, M.B., Group Health & Welfare News Special Supplement, June, 1967.

b) *The Federal Employees Health Benefits Program* by George Perrott, Consultant, and Jean C. Chase, Research Assistant, GHAA, Group Health & Welfare News Special Supplement, May, 1967.

Published under a 5-year P.H.S. Community Health Services Grant 1962-1967, for Basic Data Collection. Application for further support pending. Special Supplements — May, 1967, and June, 1967, available from: Group Health Association of America, Inc., 1321 — 14th St., N.W., Washington, D. C. 20005.

## 4. ESTIMATING THE COST OF ILLNESS

## Conducted by

Mrs. Dorothy P. Rice; U. S. Department of Health, Education, and Welfare, Public Health Service.

## Problem

Development of the methodology for measuring the economic cost of illness, disability and death for each major disease category.

## Methods

The report is a methodological study utilizing a variety of sources of morbidity and mortality data by age and sex. A model determining life-time earnings employing several discount rates was developed using cross-sectional earnings, employment data, and life tables.

## Findings

1. The total annual economic cost of illness was an estimated \$58 billion in 1963 of which \$34.3 was spent for medical care, services and supplies and \$23.8 was lost to the economy due to premature death, illness, and disability for all diseases.

2. Of the \$46.3 billion economic cost distributed among the major diagnostic groups, \$7.0 billion, or 15.2%, represent the costs of mental, psychoneurotic and personality disorders. Costs of diseases of the circulatory system rank second and diseases of the digestive and respiratory systems rank third and fourth respectively. Together, these four diagnostic group account for more than half the economic costs of illness, disability, and death from all causes.
3. In terms of the present value of earnings lost due to the 1.8 million deaths in 1963, approximately \$50 million were lost to the economy at a 4% discount rate and \$41 billion at a 6% rate. Lifetime earnings lost were highest for persons who died of diseases of the circulatory system with neoplasms second.
4. Summing the annual direct expenditures for illness, annual morbidity costs, and total earnings losses due to deaths in 1963, the total economic cost amounts to \$93.5 billion at a 4% discount rate and \$84.2 billion at a discount rate of 6%.

#### Availability of Findings

*Estimating the Cost of Illness*, Public Health Service Publication No. 947-6, May, 1966. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.

### 5. UTILIZATION OF SHORT-STAY HOSPITALS: SUMMARY OF NONMEDICAL STATISTICS

#### Conducted by

John Monroe; National Center for Health Statistics.

#### Problem

This is a report from the Hospital Discharge Survey program in the National Center for Health Statistics. The report describes utilization of short-stay hospitals by characteristics of patients and hospitals, patient diagnoses and operations performed.

#### Methods

National sample of short-stay hospitals, excluding military and veterans hospitals, and samples of medical records within hospitals. Over 100,000 abstracts of face sheets of medical records were obtained from 300 hospitals in 1965. Nonmedical information obtained at the hospital and codes of diagnoses and operations assigned by Center's medical coding staff are made on optical page reader form.

#### Availability of Findings

##### Series 13

No. 1 Patients Discharged from Short-Stay Hospitals, United States, October-December, 1964. 19 pp.

No. 2 Utilization of Short-Stay Hospitals, Summary of Nonmedical Statistics, United States, 1965. 25 pp.

No. 3 Utilization of Short-Stay Hospitals, by Characteristics of Discharged Patients, United States, 1965. 39 pp.

Diagnoses and operations report for year 1965 will be published this spring. More detailed data are available on request.

### 6. PATTERNS OF HEALTH INSURANCE COVERAGE FOR AMERICAN FAMILIES

#### Conducted by

E. L. White, A.M.; Division of Health Interview Statistics, National Center for Health Statistics.

#### Problem

To classify the hospital and surgical insurance data by size and type of family.

#### Methods

Information about health insurance was obtained from household interviews in the Health Interview Survey, conducted in a probability sample of the civilian,

noninstitutional population of the U. S. During the period, July, 1962-June, 1963, the cumulative samples included about 42,000 households containing about 134,000 persons living at the time of the interview.

#### Findings

During the period July, 1962-June, 1963 information was obtained from the civilian, noninstitutional population by the Health Interview Survey about hospital and surgical insurance coverage. Among the estimated 47,125,000 families of two or more persons, 65.8% had hospital insurance covering all members of the family, and an additional 11.7% had insurance covering some of the family members. The figures for surgical insurance coverage were 60.3% and 11.9%, respectively. Among the 11,016,000 unrelated individuals 59.6% had hospital insurance coverage and 53.3% had surgical insurance coverage.

#### Availability of Findings

Vital Health Statistics, Series 10, No. 42.

### 7. EVALUATION OF HEALTH CARE INSTITUTIONS TAXABLE AND TAX-EXEMPT BONDS

(Progress Report)

#### Conducted by

L. William Katz; Department of Health Care Administration, The George Washington University, Washington, D. C. 20006. Under a fellowship grant from The Travelers Insurance Company, Hartford, Connecticut 06115.

#### Problem

Tax-exempt and taxable bonds to finance construction of hospitals and related health facilities are offered frequently at attractive yields. The market for these bonds is limited because investors have not developed adequate criteria to evaluate these bonds. This study developed criteria for evaluation of low equity hospital debt issues when hospital revenues are the only source for debt service. The study also suggested several covenants which should be included in the hospital bond indenture.

#### Methods

Investment criteria were developed through an analysis of pertinent investment analysis literature; hospital planning, investment, design, and financial literature; hospital bond prospectuses, indentures and feasibility studies; interviews with underwriters, investment analysis, hospital financial and management consultants, and hospital administrators.

#### Findings

A hospital bond issue is considered of investment quality if from the feasibility study and independent sources it can be established:

- (1) That the hospital and its proposed programs are in response to demonstrated community needs;
- (2) That the facility is of efficient size and flexible design;
- (3) That community support is evidenced by adequate equity and public commitments;
- (4) That adequate funds will be available for operating expenses and debt service;
- (5) That the medical staff is organized and committed to the hospital;
- (6) That a competent administrator, consultant and architect have been engaged; and
- (7) That adequate nursing technical and other personnel are available to staff the facility.

The Bond Indenture should include covenants to:

- (1) Insure on-time payment of debt service;
- (2) Prudent financial practices;
- (3) Administrative continuity; and

- (4) Maintenance of accreditation, licensure and Medicare certification.

**Availability of Findings**

This study is currently under revision. The investigator expects to test some of his findings on a sample of investment analysts associated with:

- (1) Companies holding hospital securities and
- (2) Companies who do not hold hospital bonds, but who purchase revenue bonds and may be potential purchasers of hospital securities.

A final report is anticipated in late 1969. Articles on significant findings will be published in appropriate periodicals.

**8. INDEPENDENT HEALTH INSURANCE PLANS IN  
THE U. S., 1965 SURVEY**

**Conducted by**

Louis S. Reed; Office of Research and Statistics, Social Security Administration. Study was completed and report issued in 1966.

**Problem**

Gives data on enrollment and finances of independent plans, i.e., all plans other than Blue Cross-Blue Shield and Insurance Companies.

**Methods**

Questionnaire sent to all known plans. Data obtained from 582 plans covering 10,000,000 persons.

**Findings**

Since 1965, little enrollment growth for hospital service, 4% growth for surgical service, 7% growth for medical service. Prepaid Group Practice Plans, since 1964, show 3% growth for hospital service, 8% for medical service, total income increased by 26%.

**Availability of Findings**

Research and Statistics Note No. 15, September, 1967, and Research Report No. 17, Office of Research and Statistics, Health, Education, and Welfare, Social Security Administration.

**9. A QUANTITATIVE ANALYSIS COMPARING SELECTED CHARACTERISTICS  
OF LONG-TERM CARE INSTITUTIONS WITHIN THEIR VARIOUS  
OWNERSHIP AND CONTROL CLASSIFICATIONS**

**Conducted by**

Department of Health Care Administration, The George Washington University  
Harold E. Green, M.B.A., Research Coordinator and Principal Investigator.

**Problem**

The study will compile national data on long-term care institutions by bed size and ownership and control. Emphasis will be placed upon the influence of ownership and control on such characteristics as personnel, patients, patient care services, and operating and expansion costs.

**Methods**

From a population of 19,272 institutions throughout the nation a stratified random sample was selected. Data was collected by means of questionnaires and on-site visits. Project was started in November, 1967, with a completion date of August, 1969.

**Availability of Findings**

The final product will be a series of monographs presenting depth analysis of the findings. A final report is expected in August, 1969, and articles on significant findings will be published in appropriate professional periodicals and journals.

10. HEALTH AND INSURANCE BENEFITS FOR  
RETIREED WORKERS AGE 65 AND OVER

Conducted by

U. S. Department of Labor, Bureau of Labor Statistics; Dorothy R. Kittner.

Problem

Determine the types and levels of health benefits extended to workers who retire from active employment on reaching age 65, the effect of Medicare on health benefits for this group and the amount of life insurance coverage extended to them by selected negotiated health and insurance plans.

Methods

The information for this study was collected by questionnaires mailed to negotiators (company and union officials) or administrators of plans included in BLS Bulletin 1502, *Digest of 100 Selected Health and Insurance Plans Under Collective Bargaining, Early 1966*. The benefits of each plan, identified by name of company and union, will be summarized and presented separately in a tabular form designed to facilitate comparisons between plans. These summaries will update the information shown in the retiree's section of BLS Bulletin 1330, *Digest of One-Hundred Selected Health and Insurance Plans Under Collective Bargaining, Winter 1961-62*, published in June, 1962. To determine the effect of Medicare on private plans and adaptations of private plans to it, current plan benefits will be compared with those provided by the same plan prior to July, 1966, the effective date of Medicare's hospital insurance.

Findings

Current benefits extended to retirees and their dependents age 65 and over by 100 selected negotiated plans and the effect of Medicare on benefits previously provided by these plans.

Availability of Findings

To be published: A BLS Bulletin, *Supplement to Digest of 100 Selected Health and Insurance Plans Under Collective Bargaining, Early 1966: Benefits for Retired Workers Age 65 and Over*, will be available from the Government Printing Office in August, 1968. An article summarizing the benefits described in the Supplement and discussing the effect of Medicare on negotiated plans will appear in the *Monthly Labor Review* in the late summer of 1968.

11. CITY WORKER'S FAMILY BUDGET FOR A MODERATE  
LIVING STANDARD, AUTUMN 1966

Conducted by

U. S. Department of Labor, Bureau of Labor Statistics; Mrs. Helen H. Lamale.

Problem

Determine estimated costs of maintaining a moderate standard of living for a four-person family — an employed husband, age 38; a wife not employed outside the home; and two children, a girl age 8 and a boy age 13 — at fall 1966 prices. Estimates to be updated to spring 1967 and annually thereafter, together with estimates for higher and lower standards for the same family type. Budgets include estimates of the cost of prepaid health insurance.

Methods

Based on 1960-61 Survey of Consumer Expenditures, supplemented by data from National Health Surveys, the budget allowed a family group contract, obtained through the husband's place of employment, which provided for full coverage of 70 days' care in a semi-private hospital room, all normal ancillary services and supplies, and surgical benefits. Premium data were obtained for Blue Cross-Blue Shield plans and for commercial insurance policies. The annual premiums for these policies reflect estimates of amounts paid by employers so that the cost estimates used in the budget reflect only that part of insurance premiums paid by families. Data are available for the average of United States urban areas, individually for 39 metropolitan areas; and for the average of nonmetropolitan areas in four geographic regions.

Findings

The average annual cost of such a policy in the urban areas surveyed was \$219.

Among individual areas, the cost ranged from \$175 in Austin, Texas, to \$278 in Detroit, Michigan.

#### Availability of Findings

BLS Bulletin 1570-1, *City Worker's Family Budget* (pages 19-20), available from the Government Printing Office, Washington, D. C. 20402. Price: 30¢.

### 12. EFFECT OF A PREPAYMENT PLAN ON MENTAL HEALTH PROGRAMS

(Progress Report)

#### Conducted by

Robert Pfeiler, M.D.; American Psychiatric Association and Michigan Health and Social Security Research Institute; supported by National Institute for Mental Health grant MHO9221-01,02.

#### Problem

Study the principles, relationships and situations that develop as users, insurers, purchasers, and servicers cooperate in building local systems for providing mental health programs and services under varied patterns . . . to determine the problems of a nationwide prepaid insurance plan supported by the voluntary sector of psychiatry and by industry and labor, and to define and develop the research potentials deriving from this new system of services.

#### Methods

- (1) Established liaison with local units of labor and psychiatry.
- (2) Utilization and cost studies being conducted by MHSSRI.
- (3) APA surveyed 52 district branches and 83 liaison representatives.

#### Findings

APA Survey: (1) 48% of the liaison representatives had been in contact with local UAW insurance carrier prior to program inception; (2) 17% stated that new services and facilities had been established as a consequence of the program; (3) 15% of the liaison representatives had been contacted by local and regional UAW officials; (4) 35% of the liaison representatives felt UAW membership was aware to some degree of their penetrating care program; (5) most thought utilization was less than anticipated.

#### Availability of Findings

Project is continuing. Phase II reports will emanate from MHSSRI. Report on Phase I available from American Psychiatric Association, 1700 Eighteenth Street, N.W., Washington, D. C. 20009; other reports on Phase I and Phase II may be forthcoming.

### FLORIDA

### 1. AUTOMATED PLANNING AND CONTROL OF DIETARY FUNCTIONS TO PLANNING AND CONTROL OF HOSPITAL DIETARY FUNCTIONS

#### Conducted by

J. D. Fellers; University of Florida and Health System Research Division of HEW, PHS.

#### Problem

Systems for automated recipes (with nutrition, cost controls — using a menu-computer planned or dietitian planned) automatic issues with cost information (in advance) automatic purchasing through P. O. to vendor; automated system or receiving and automated cost accounting (as follow-up and feed back).

#### Methods

Methods based on actual system planned and tested in live actual operation.

#### Findings

The manual automated system to be used for mathematical computer formula produced benefits over conventional systems in error reduction, confusion reduction, labor saving and stability, run out and emergency reductions, high accuracy in forecasted needs and personnel incentives (attitude stimulation and pride in work).

## Availability of Findings

Numerous publications on the manual system and mathematical formula including:

- (1) Monogram — Fellers, John D. and Gue, Ronald L., Ph.D. "Computer Planning and Control of Dietary Functions" Univ. of Florida, Pub. 8/65.
- (2) a. John D. Fellers. "Electronic Data Processing for the Food Service Industry," *International Society of Food Service Consultants Manual*.  
b. Excerpted as "EDP for Food Service Industry," *Kitchen Planning*, Vol. 4, Second Quarter, 1967.
- (3) Gue, Ronald L. & Liggett, John C. "Selective Menu Planning by Computer," Monogram *Computer Science Center SMU*, May, 1967.

2. THE HILLSBOROUGH DEMONSTRATION PROJECT,  
AN EXPERIMENT IN QUALITY CONTROL OF MEDICAL CARE

## Conducted by

Florida Medical Association; Hillsborough County Hospital and Welfare Board; Florida State Welfare Department.

## Problem

(a) The feasibility of involving a medical society in quality control of care offered a sizable welfare population segment. (b) Ascertain costs and charges which could be of assistance in developing a Title XIX Program in Florida.

## Methods

Population: 6,526 Old Age Assistance Recipients; 227 Blind (Categorical Recipients); 2,032 Permanently and Totally Disabled (Categorical Recipients). Data: Full comparable Part B Medicare benefits for covered persons and outpatient hospital services for covered persons.

Analysis: 20,000 claims and close to \$300,000 in claims funds (when all accounts are settled).

## Findings

*Average amount billed per claim	Average amount paid per claim
\$24.47	\$15.38

\*Payment made "in full" either by the Project or by Medicare.

\*Four physicians "identified" for possible poor quality medical care, and two physicians "identified" for possible excessive drug prescribing practices. A committee of local physicians reviewed claims and made the value judgments.

## Availability of Findings

Research publication available from Florida Blue Cross-Blue Shield, Post Office Box 1798, Jacksonville, Florida 32201.

3. THE IMPACT OF THE 1965 SOCIAL SECURITY AMENDMENTS  
ON PRIVATE HEALTH INSURANCE

## Conducted by

O. D. Dickerson, Ph.D.; Florida State University, American Risk and Insurance Association, The Cooperative League of The United States of America.

## Problems

To describe the coverage, benefits and financing of the Old-Age Survivors and Disability Insurance system as amended in 1965 and of the new Hospital Insurance and Supplementary Medical Insurance system introduced in the Social Security Amendments of 1965 and to attempt to identify the changes these programs necessitated in private health insurance.

## Methods

Since the study was descriptive, the major source of materials were the Social Security Act as amended, the *Medicare Bulletins* and *Title 19 Bulletins* of the Health Insurance Association of America, oral discussion with insurance industry



leaders, and the policy and rate filings of insurers with the Florida Insurance Department.

#### Findings

A massive new insurance program has been created with more than 18 million insured and has pre-empted a significant segment of the market. Private insurers have been forced to redesign coverages to avoid duplication with Title 18 hospital and medical benefits and many companies no longer issue coverage renewable beyond age 65. The benefits of group disability income contracts must be reduced to avoid overpayment in view of the changed definition of disability and the higher benefit amounts for disability income under the Social Security Law. This will become more severe due to the 1967 Amendments with further benefit increases and more liberal eligibility requirements for young workers. This study is continuing with additional financial support from the Reim Foundation.

#### Availability of Findings

"The 1965 Social Security Amendments and Private Health Insurance" by O. D. Dickerson, *Annals of the Society of C.P.O.U.*, September 1966, pp. 227-282. Available from the Society of Chartered Property Casualty Underwriters, 301 Penn State Building, Media, Pa. Reprint of article 50¢; complete issue \$2. Check must accompany the order.

#### 4. EVALUATION OF PUBLIC HEALTH PROGRAMS FOR THE AGED

##### Conducted by

H. W. Carter, M.D.; Pinellas County Health Department through Florida State Board of Health, Jacksonville, Florida.

##### Problem

Health needs of the aged, formulation of public health programs to satisfy major needs, critical evaluation of programs applied on experimental basis, social characteristics and social relationships of an aged, predominantly transplanted population, residing in a "retirement area."

##### Methods

Household survey of older persons: social characteristics and relationships, personal history, attitudes, health status and needs, health care practices and costs of health care. Application of scientific method to determine success of public health programs designed specifically to satisfy certain health needs of the aged.

##### Findings

In some instances, certain programs have been quite successful and others have fallen considerably short of proposed and planned objectives. It is clearly evident that all phases of community programs require careful planning if they are to be successfully initiated and conducted. Their acceptance in a conservative community may hinge on the proper presentation of ideas and plans to civic and professional leaders.

##### Availability of Findings

"The Aged and Chronic Disease—Research in a Local Health Department," monograph number 9, Florida State Board of Health, Jacksonville, Fla., 32201. Specifically chapters 7 and 9. Monograph available without charge upon request.

#### 5. A STUDY OF THE INCREMENT IN REVENUE FROM INPATIENTS 65 AND OLDER SINCE MEDICARE IN TWO SELECTED HOSPITALS

##### Conducted by

Frank J. Reichert, Program in Health and Hospital Administration, University of Florida.

##### Problem

To obtain a measure of the change in inpatient revenue received from patients 65 years of age and older at two selected hospitals since the start of Medicare and to isolate component factors contributing to this change.

**Methods**

Accounting records of Alachua General Hospital and Bradford County Hospital inpatients 65 and older admitted during the first calendar quarter of 1966 and 1967 were examined to determine the change in revenue from this segment of the patient population for the two study periods. This change was divided into price and quantity variance components through a modification of price-quantity variance analysis devised especially for this project. These components were then examined to determine the possible effect of Medicare on revenue. Finally, data from the two hospitals studied were compared to determine similarities and differences.

**Findings**

In the two hospitals studied there has been a great increase in revenue from patients 65 and older since the introduction of Medicare. Part of this increase is the result of changes of rates and improvement in collections (price variance). The remainder is attributable to changes in utilization by patients 65 and older (quantity variance). With the assignment of a reasonable portion of the quantity variance to Medicare, it appears that Medicare has had a considerable effect on the total variance. However, at least 1/4 of the total change is the result of other factors not associated with Medicare and not isolated in this paper.

6. AN EXAMINATION OF TRENDS IN SELECTED ANCILLARY SERVICES  
PROVIDED HOSPITAL PATIENTS

**Conducted by**

James F. Vickery, Program in Health and Hospital Administration, University of Florida.

**Problem**

The purpose of this study was to test the hypothesis that there has been an increase in both the quantity and variety of selected ancillary services provided selected inpatients of the Shands Teaching Hospital.

**Methods**

The procedure selected involved an examination of the medical records of patients treated for three diagnoses in the years 1960, 1963, and 1965. The purpose of the review of these records was to identify and enumerate the services provided to the patient by the departments of Radiology, Physical Therapy, the Clinical Laboratory, the Electrocardiogram Unit and those services classified as surgical procedures. A statistical test known as the Chi-Square Criterion was administered to the data accumulated in order to determine which of several theoretical distributions best reflected the pattern observed here. Five of the eight groups of services did meet this criterion while the other three demonstrated a pattern reasonably close to that established by this criterion. On the basis of this evidence it was determined that a Poisson distribution satisfactorily described this data. A second statistical testing procedure known as the "F" test was utilized to examine changes in the twenty-four combinations of years and services to test for statistical significance.

**Findings**

The total number of each of the eight ancillary services in the treatment of all three conditions increased in the period 1960-1963 with the exception of one service not utilized in either year in the treatment of one diagnosis. Sixteen of the twenty-four combinations increased in the 1963-1965 period and in the 1960-1965 span, twenty-one of the twenty-four were utilized in greater numbers. On a per patient basis, twenty of these groups increased, eleven in sufficient numbers to be considered statistically significant. In the 1963-1965 period only thirteen increased but in the overall 1960-1965 time span twenty of the twenty-four combinations increased. Similar trends were revealed when the same data was considered on a per patient day basis. Application of a test for statistical significance revealed that a substantial majority of the services examined were utilized in significantly greater numbers in succeeding years. These findings appear to provide adequate support to the stated hypothesis. Although the results of the test were not unanimous, they do offer a rather strong suggestion to the premise that there was a significant increase in the quantity and variety of ancillary services provided to certain hospital patients in the years examined.

GEORGIA

1. OVERHEAD HOSPITAL COSTS AND PRICING IN A  
SHORT-TERM GENERAL HOSPITAL

Conducted by

Harold A. Cohen and National Institutes of Health.

Problem

Use of cost information in hospital decision making.

Methods

Theoretical and statistical — multi-repression analysis, questionnaires.

Findings

Unit of output, nature of employee scheduling, average cost curve, price theory applications.

Availability of Findings

January, 1967, *Southern Economic Journal*, March 2, 1967, Public Utilities Fort-nightly. February, 1968, Joint Economic Committee Manpower Symposium. University Microfilms.

2. THE DENTAL STATUS OF MENTALLY RETARDED CHILDREN  
IN GEORGIA

Conducted by

John E. Butts, DMD; Branch of Dental Health, Georgia Dept. of Public Health.

Problem

(1) Blocks to dental care for mentally retarded children in Georgia inherent in dental profession; (2) Blocks inherent in parents of M.R. children; (3) Dental diseases prevalent in M.R. children.

Methods

(1) Survey of blocks among dental profession based on stratified sample of 101 dentists in private general practice in Georgia; (2) Survey of stratified sample of 1886 M.R. children to include DMF, df, OHI-S and RPI scores; (3) Survey of blocks by questionnaire of parents of children.

Findings

M.R. children, in Georgia, compared to their "normal" counterparts have: (1) lower incidence of carious lesions; (2) higher prevalence of untreated carious lesions; (3) significantly poorer oral hygiene; (4) significantly more periodontal disease.

Availability of Findings

*Journal of Public Health Dentistry*, Vol. 27, No. 3, 4, Vol. 28, No. 1, Summer 1967; Fall 1967; Winter 1968.

HAWAII

1. OUTPATIENT PSYCHIATRIC CARE BENEFITS

Conducted by

R. J. Kiessling; Hawaii Medical Service Association.

Problem

Incidence, average visits per case, etc.

Methods

Tabulation of one year's experience.

Findings

Psychotherapy Out-Patient visits.

(a) Three cases per 1,000 members per year (Cases having at least 2 visits each);

(b) 6.3 average visits per case; (c) Age of patients ranged from 9 to 67 with mean age of 37 years; (d) Sex of patients equally divided.

#### Availability of Findings

Hawaii Medical Service Association.

### IDAHO

#### 1. THE IDAHO REGIONAL UTILIZATION REVIEW PROJECT

(Progress Report)

#### Conducted by

Warren B. Ross, M.D.; Idaho Foundation for Medicine and Biology, Boise, Idaho.

#### Problem

To design a regional utilization review plan relating to rural hospitals and extended care facilities with small staff organization, and development of a back-up data base for hospitals and extended care facilities in such a rural state.

#### Methods

The design elected is a computer-based analysis of hospital services. Input is information gleaned from patient records by record room personnel, recorded in numeric code, and transmitted to a central office by teletypewriter for computer analysis. Output is lists of Medicare and non-Medicare patients upon whom action by the utilization committee is indicated. Data is stored for later recall and analysis.

#### Findings

As of this time the investigation is sufficiently developed to state that computer screening for utilization review is feasible and effective, providing turn-around reporting within 24 hours. Data collection with resultant comparative and correlative studies will provide usable administrative support, and quality of care measurement when sufficient material has been stored.

#### Availability of Findings

The project is now in the demonstration-model phase and expansion is anticipated in the next four to eight weeks. The findings are therefore incomplete and only preliminary reviews of the project have been presented with none published to date.

### ILLINOIS

#### 1. HOSPITAL REIMBURSEMENT STUDY

(Progress Report)

#### Conducted by

Colin W. Churchill; American Hospital Association.

#### Problem

A study designed to measure the impact on hospital finances utilizing such independent variables as population, income, and degree of population urbanization.

#### Methods

Samples drawn using Hospital Administrative Services data for hospitals in Michigan, Indiana, Illinois, and Wisconsin. Data compilation completed. Analysis being performed by David Drake, Ph.D. of the American Hospital Association staff.

#### 2. IMPACT OF WATER FLUORIDATION ON THE PRACTICE OF DENTISTRY

(Progress Report)

#### Conducted by

University of Illinois, College of Dentistry.

#### Problem

Determination of outstanding and significant differences between dental practices in fluoride and fluoride-deficient communities.

**Methods**

Two sets of communities have been paired for socioeconomic, demographic and generic similarities. The only difference between these sets of communities is that one of each pair is fluoride-deficient and the other has a naturally fluoridated community water supply. Data were acquired directly from dentists regarding patient services administered during one representative week. Data for the same week were acquired from 99% of the offices visited. Data now in the process of being analyzed. First paper of findings to be presented at the International Association of Dental Research Meeting, San Francisco, California; March, 1968.

**3. MEDICAL CARE COSTS AND VOLUNTARY HEALTH INSURANCE:****A THREE COUNTRY (GREAT BRITAIN, SWEDEN, U. S.) STUDY****Conducted by**

Odin W. Anderson and Ronald Andersen; Sponsor: U. S. Public Health Service Research group: Center for Health Administration Studies, University of Chicago.

**Problem**

Comparison of development, structure, and services provided by health service systems in Sweden, Great Britain, and the United States.

**Methods**

Based on parallel social survey data from Sweden and the United States and national aggregate data on expenditures and use from all three countries. Other sources of data include social and political literature from the three countries and interviews with leaders of government, business, health services administration, and academically in each country.

**Findings**

Attempt to understand health services system and the medical care they provide in the context of the broader political and social characteristics of the country. The systems under study are considered to represent points along a continuance of structure of health service systems with Great Britain being "most structured," the United States "least structured," and Sweden somewhere in between.

**Availability of Findings**

- 1) Odin W. Anderson, "Health Service Systems in the United States and Other Countries." In L. J. Degroot ed. *Critical Comparison. Medical Care; Social and Organizational Aspects*. Springfield, Illinois: Thomas, 1966.
- 2) Odin W. Anderson, Towards a Framework for Analyzing Health Service Systems. *Social and Economic Administration*, Volume 1, 1967.
- 3) Ronald Andersen, Odin W. Anderson and Bjorn Smedby, "Perception of and Response to Symptoms of Illness in Sweden and the United States, *Medical Care*, Volume 6, 1968.

**4. A DECADE OF PERSONAL HEALTH SERVICES:****TRENDS IN USE AND EXPENDITURES****Conducted by**

Odin W. Anderson and Ronald Andersen; Sponsor: National Institute of Health, U. S. Public Health Service; Conducted by Center for Health Administration Studies and National Opinion Research Center, University of Chicago.

**Problem**

Investigations of trends in families' use of and expenditures for the Health Service system, and how they go about paying for these services from 1958 through 1968.

**Methods**

Through parallel studies based on representative samples of the nation's families. Additional information collected from hospitals, employers, and insuring organizations about hospitalization and health insurance coverage.

**Findings**

Shows patterns of increasing use, expenditure, and health insurance coverage.

Analyses these trends in terms of age, sex, income, and other basic population characteristics.

#### Availability of Findings

Final report published as:

Ronald Andersen and Odin W. Anderson, *A Decade of Health Services: Social Survey Trends in Use and Expenditures*, Chicago: University of Chicago Press, 1967.

### 5. NURSE-PATIENT CONFERENCES AND PATTERNS OF COMPLIANCE

(Progress Report)

#### Conducted by

NIH/conducted by Dr. D. Tagliacozzo and Dr. J. Lashof and associates at the Illinois Institute of Technology and Presbyterian St. Luke's Clinic.

#### Problem

To ascertain:

- 1) The outpatient's orientations towards the medical world, illness, and social environment relevant to health care;
- 2) How nurse-patient sessions may facilitate patient knowledge of both coping with illness and illness prevention;
- 3) How the patient's orientation, including knowledge gained from nurse-patient sessions, and experiences in the outpatient clinic affects his compliance pattern.

#### Methods

- a) Population: principally Negro outpatients with chronic diseases in an outpatient medicine clinic.
- b) Types of data: attitude questionnaire, record keeping of clinics, and physical tests (e.g., urinalysis).
- c) Design: patients will be divided into three groupings — individual nurse patient sessions, group patient sessions and control group patients.
- d) Method of analysis: longitudinal analysis of compliance with special focuses on changes in orientation and compliance behaviors. Much of the data will be tabulated by IBM machine, but a significant portion will be descriptive and non-tabulated.

Data now in process of being analyzed. Copies of papers will be made available.

### 6. EXPENDITURES FOR AND USE OF DENTAL SERVICES

AMONG AMERICAN FAMILIES

(Progress Report)

#### Conducted by

George Y. Ogawa; Center for Health Administration Studies, National Opinion Research Center, American Dental Association.

#### Problem

To investigate family expenditures and use patterns for dental care during 1964.

#### Methods

3,165 families were selected on the basis of area probability sample. Data on expenditures and utilization of dental care obtained by personal interviews and verified by interviews with dentists referred to by the family respondents.

### 7. ECONOMIC DEPENDENCY, USE OF MEDICAL SERVICES

AND THE MEANS TEST

#### Conducted by

Odin W. Anderson; Center for Health Administration Studies, University of Chicago.

**Problem**

Poverty and the use of services.

**Methods**

Literature review, precollected data, leading to a conceptual framework for a major study.

**Findings**

Concepts were derived and presented including a summation of previous work in this area.

**Availability of Findings**

Final Report available from: Center for Health Administration Studies, University of Chicago. William C. Richardson; *Division of Economic Dependency*. Health Administration Perspectives No. A4, \$1.25.

**8. MEDICAL AND HOSPITAL SERVICES IN SOUTHERN ILLINOIS****Conducted by**

Ray E. Wakely; Southern Illinois University; Community Development Service and Office of Research and Projects.

**Problem**

Distribution and selected characteristics of physicians. Hospitals and Nursing Homes in Southern Illinois and the state.

**Methods**

Distribution, age, specialty, and ratio of number of population by number of physicians for counties and centers of different population size. Distribution, bed capacity, and special services of principal classes of hospitals by county and center. Distribution and state approval of nursing homes in Southern Illinois.

**Findings**

Serious lack of medical practitioners and medical school lacking many services outside the city of Chicago. Hospitals plentiful but small, nursing homes are mostly unlicensed, serving not as nursing homes but as boarding homes.

**Availability of Findings**

Wakeley, R. E., C. E. Lively, and Bert Kellerman. Number, Distribution and Age of Physicians in Southern Illinois.

Hospitals and Nursing Homes in Southern Illinois:

Area Services Bulletins #3 and 4, Southern Illinois University, Carbondale, Illinois 62901.

**9. THE EFFECT OF MANAGERIAL CONTROLS ON HOSPITAL COSTS**

(Progress Report)

**Conducted by**

Duncan Neuhauser; Center for Health Administration Studies, University of Chicago.

**Problem**

To study the effect of administrative controls on hospital functioning.

**Methods**

Data are from 390 hospitals, which participated in the Hospital Administrative Services and Management Review Programs of the American Hospital Association by the end of 1966. The relationships between budgets, administrative man hours, the administrator's training, costs, revenue, and hospital size are being studied. Two working papers will shortly be available:

(1) The Use of Budgets in Hospitals.

(2) Does the Administrator with a Master's Degree Do a Better Job?

## 10. PHYSICIAN RESPONSE TO SCREENING TEST RESULTS

## Conducted by

John J. Williamson, M.D.; Staff of Rockford Memorial Hospital and the Office of Research in Medical Education, University of Illinois College of Medicine, Chicago.

## Problem

Is it feasible to identify objectives for, and evaluate results of, continuing Medical Education through Patient Care Research Study.

## Methods

Physician response to unexpected abnormalities on routine screening hemoglobin, urinalysis and fasting blood sugar results was measured by chart review; and the data presented to the hospital staff for analysis and identification of potential problems. Instructional effort planned and agreed upon by the staff was provided and the study of response to these screening tests repeated to determine effect of education and to plan subsequent instruction if needed.

## Findings

- (1) The functions of patient care research and continuing medical education complement each other and seem to be logical steps to improve medical care.
- (2) Re-emphasizes the observation that deficiencies in patient care usually involve multiple determinates, the more important of which must be identified if significant improvement is to be achieved. Without such data, one can only speculate about "who" needs to learn "what."
- (3) Emphasizes that in the evaluation of educational effectiveness, measurement of what physicians actually do is more important than recording what they claim they should do.
- (4) Nonverbal educational stimuli may be more effective than information and logic in improving behavior.
- (5) A continuing cyclic effort seems essential if desired levels of performance are to be achieved and maintained. In this instance, further action will be necessary to augment the quantitative gains that followed the use of fluorescent tape and especially to improve further the qualitative adequacy of response.

## Availability of Findings

Williamson, John W., *The Journal of American Medical Association* 201: 938-942 (18 Sept.) 1967.

## 11. HOSPITAL PANEL SURVEY

## Conducted by

James B. Cobb; American Hospital Association.

## Problem

This study gathers monthly data on utilization, personnel, and financial figures for Non-Federal short-term general and other special hospitals. The utilization data is collected for categories of patients over and under age 65.

## Methods

The universe is a disproportionate random sample of approximately 650 hospitals. Each month's reported data is projected to the entire universe of approximately 5,800 hospitals. Data is utilized by bed size and by census region.

## Findings

The principal findings are a series of trend tables and projected data which are reported for seven categories of utilization information. In addition, a special indicator is prepared each month which provides a more in-depth analysis on one particular aspect of the collected data.

## Availability of Findings

The projected data is published as "Hospital Indicators" in the 16th issue each month of HOSPITALS, Journal of the American Hospital Association.



## 12. SURVEY OF HOSPITAL SERVICE CHARGES

(Progress Report)

## Conducted by

James B. Cobb; American Hospital Association in connection with the Health Insurance Council.

## Problem

Study is designed to collect information on charges made by hospitals to their patients for services rendered. Study includes normal accommodation, intensive care, ECF's, certain selected drugs and routine laboratory procedures in all non-governmental general hospitals. The data will be analyzed by ownership, bed size, and Standard Metropolitan Statistical Areas. Findings will analyze charges by hospitals to their patients. Since this is a continuation of a series of studies conducted since 1960, certain data can be compared from year to year for time analysis. Results of the study will be published by the American Hospital Association some time in the summer of 1968. The publication will include detailed tables as well as statistical summary of the data.

## 13. BLUE CROSS PROVISION OF COORDINATED HOME CARE BENEFITS

## Conducted by

Richard J. Buxbaum; Research Division (Special Studies Program), Blue Cross Association.

## Problem

The survey examined the extent to which Blue Cross Plans were providing benefits structured specifically for coordinated home-care programs. The investigation covered both the utilization and cost experience of those Plans which were providing these benefits.

## Methods

A survey was made of all 75 Blue Cross Plans. Those Plans which replied positively to the question of whether or not they provided benefits for coordinated home-care programs were asked for the form in which data was routinely kept, the services rendered under the programs were requested, average expense per home-care case was requested, as well as: expense per home care day, dollar amount of claims paid, number of claims paid, percent of claims paid for patients under 65 years, and five most frequent diagnoses. (For 1966)

## Findings

17 Plans (23% of total of Plans) replied that they were providing benefits for coordinated home care programs. Nine Plans offered benefits for hospital-based home-care programs; five covered community-based programs, and the remaining covered some combination. Expense per case was characterized by a median expense of \$229.50. The median expense per home-care day was \$5.98, or \$6.08 for the high volume Plans of Rochester, New York, New York City, and Detroit, Michigan. The average percent of claims paid for persons under 65 for these "high-volume" Plans was 59.9%. "Hospital days saved" were calculated by 8 plans; for these Plans the range for days saved was from 13 to 22. (See Oct. '67 Inquiry for other findings.)

## Availability of Findings

See: "Blue Cross Provision of Coordinated Home Care Benefits," *Inquiry*, October, 1967. by R. J. Buxbaum.

## 14. SOCIO-ECONOMIC CHARACTERISTICS RELATED TO SELECTED HEALTH INDICES IN CHICAGO AND SUBURAN COOK COUNTY

## Conducted by

Jean E. Bedger; Co-sponsors: Welfare Council of Metropolitan Chicago, U. S. Children's Bureau, and Illinois Department of Public Health.

## Problem

The investigation focused on the geographic distribution of health rates, relating them to socio-economic characteristics in an attempt to understand health differentials.

**Methods**

**Methodology:** Chicago and Suburban Cook County demographic and health data were gathered and related to income groups. Also data on 75 communities of 20,000 or more population in Chicago and suburbs were used in a regression analysis to relate 15 socioeconomic and health variables to each other.

**Findings**

Socio-economic status and infant mortality are inversely related. Infant mortality rates steadily increase as income levels decrease. The pre-maturity rate was twice as great in the low income groups as the high income groups. The rate of illegitimacy is eight times higher in the lowest level. After a certain necessary minimum of income is available, additional income has little effect on health factors. The health rates for the non-white population in high income areas had rates comparable to those in low income non-white areas. This supports the hypothesis that disparity in health rates among non-whites reflects economic differences rather than racial differences.

**Availability of Findings**

PART II Socio-economic Characteristics Related to Selected Health Indices in Chicago and Suburban Cook County is available from the Welfare Council of Metropolitan Chicago, 123 West Madison Street, Chicago, Illinois. \$1.50. Also condensed highlights of the report are given in an article in Public Health Reports, Vol. 81, No. 9, September, 1966, by Jean E. Bedger.

15. IDENTIFICATION OF MEDICAL-SOCIAL PROBLEM AND  
PROPOSED SOLUTION, AS SEEN BY DOCTOR, CASEWORKER, AND PATIENT

**Conducted by**

Special Fellowship given by USPHS. M. E. Heyman; conducted as doctoral study at University of Chicago.

**Problem**

The initial collaboration between doctor, patient, and social caseworker in a general hospital and its relationship to the outcome of the case, (the status at case closing of the medical-social problem referred).

**Methods**

Three sets of factors were examined separately and finally together in relation to case outcome.

- (1) Problem, solution, and means as they interrelated, then separately, and in combination as related to case outcome;
- (2) General factors related to the patient as a problem-solver (his motivation, capacity, and the role of his family) considered in relation to case outcome; and
- (3) Specific factors related to the client in his role as patient and to the hospital environment itself considered in relation to case outcome.

Systematic case analysis. Data for each case were extracted from:

- (1) Three schedules completed by the workers;
- (2) Two interviews with each worker;
- (3) The social service record; and
- (4) the medical chart.

Reliability was tested through degree of agreement secured between investigator's ratings and those of experienced casework judges. The source materials were assumed to have validity, i.e., that the data derived from them truly represented the transactions involved.

**Findings**

- (1) Consensus among the three collaborators — their agreement on the problem, solution, and means — appears to be less important for favorable outcome than patient motivations.

- (2) Although less important for favorable outcome than patient motivation, consensus among the collaborators is still found to be important because without it, positive patient factors are less associated with favorable outcome.
- (3) Nonagreement at point of referral, that is, initial inability of a collaborator to identify the problem, solution, or the means, emerged as a separate and unanticipated category.

#### Availability of Findings

University of Chicago, Ph.D. dissertation. Available in microfilm at University of Michigan. One article based on findings has already been published in *Social Casework*, May, 1967.

### 16. CHICAGO BOARD OF HEALTH MEDICAL CARE REPORT

#### Conducted by

Chicago Board of Health by a Research Group directed by Joyce C. Lashof, M.D.

#### Problem

To illuminate the pattern of medical care now existing in poverty areas and to propose specific programs to meet the most urgent needs identified.

#### Description

Multiple secondary statistics were compiled and analyzed, and a special questionnaire was developed to glean perceptions of the health problems and needs. The poverty area, compared to the non-poverty area of Chicago, was found to have a 50% higher birth rate, 400% more non-hospital births, 100% more mothers under 20, 450% more illegitimacy, 200% higher premature birth rate, nearly 60% higher infant mortality, 200% more new TB cases, 550% more new VD cases, 50% lower rate of physicians per capita and a 70% lower rate of board certified specialists per capita. A limited number of reports are available upon request.

### 17. PERIODIC SURVEY OF PHYSICIANS

#### Conducted by

American Medical Association Department of Survey Research by C. N. Theodore and G. E. Sutter.

#### Problem

1. Compare sample information with AMA records on specialty and activity.
2. A descriptive profile of the physician population.
3. An estimation of utilization of physicians' services in terms of work weeks per year, hours per week, and patient visits per week.
4. Feasibility of periodic survey.

#### Methods

Questionnaires sent to 3,544 of the 179,641 physicians known to be in private practice. The response rate exceeded 80%. Sample was designed to reflect office practice orientation.

#### Findings

1. 88% of sample group reported specialty practices coinciding with AMA records.
2. Sample showed an average weeks of practice per year of 47.9 weeks average, direct care per week of 45.3 hours, and an average of 94.9 patient visits per week.
3. Geographic and specialty variations are also shown.

#### Availability of Findings

*JAMA*, Vol. 202, No. 6, 11-6-67, pp. 516-24.

18.

## END RESULT OF PATIENT CARE:

## A PROVISIONAL CLASSIFICATION BASED ON PHYSICIAN REPORTS

## Conducted by

Paul J. Sanazaro, M.D., and John W. Williamson, M.D.; Association of American Medical Colleges, Johns Hopkins University, Human Sciences Research, Inc., PHS Grant CH00148.

## Problem

Measure end result of patient care.

## Methods

Modified critical incidence technique. Source was group of 1211 full-time private internists who held active teaching appointment at 20 medical schools in 14 states. Each was asked to describe 3 "effective" and 3 "ineffective" performances which they had personally observed in the past 12 months.

## Findings

The published report is based upon provisional classification of 6276 end results. Results were not intended to be "representative" — rather were to test the technique. The comprehensive description of categories of outcome is proposed as a point of departure for developing specific criteria and techniques for validating current professional judgments of what constitutes effective performance. Further empirical studies are urged to test whether the classifications, and its future modifications can provide an index for objectively and reliably assessing patient care.

## Availability of Findings

*Medical Care*, Vol. 6, No. 2, April 68, p. 123.

## INDIANA

## 1. INTERAGENCY RELATIONS IN PROVISION OF HEALTH SERVICES

(Progress Report)

## Conducted by

Robert L. Eichhorn; Purdue University, Department of Sociology and Division of Community Health Services (USPHS)

## Problem

The relations among agencies concerned with tuberculosis control in the Calumet region of Indiana.

## Methods

Observation, interview, and mail questionnaire sent to agencies and certain individuals. The findings will appear in a Ph.D. dissertation prepared by Jere A. Wysong of Purdue University. A summary report will also be submitted to the USPHS in August, 1968.

2. THE COMPILATION, DECOMPOSITION AND ANALYSIS OF  
SELECTED DRUG DEMAND ECONOMIC TIME SERIES

## Conducted by

Christopher A. Rodowsaks and Robert V. Evanson; Department of Pharmacy Administration, School of Pharmacy and Pharmacal Sciences, Purdue University.

## Problem

Originally, to see if some essence of basic and/or model stocks could be set up for a pharmacy that could be applied to pharmacies. When this became obviously impossible from the data, the problem became one of analyzing the data of three different types of pharmacies to ascertain the nature of demand as it might be related to inventory and buying procedures.

## Methods

The study design included the pharmacies of the Purdue University Health Center,

Willimantic Hospital, and a retail pharmacy. All have sufficient Rx volume in units to offer significant data. Files were audited. Data were reduced to cards, and an analysis was made using the Census Bureau II program for data processing. Original terminal distribution demand time series were compiled for total prescription activity and the demand for selected prescription drug products in a community and a clinic pharmacy.

#### Findings

Seasonal stability was significant in all national, all clinic, and most hospital series, but only in the total prescription activity series of the community pharmacy. Variations in seasonal fluctuations and trend-cycle movements are described.

#### Availability of Findings

The Ph.D. thesis is on file in the Purdue libraries system for loan according to university rules. Microfilm of abstract or thesis is available through the usual channel for thesis microfilms.

### 3. PRICES AND PATENT PROTECTION IN THE ETHICAL DRUG INDUSTRY

#### Conducted by

Hugh D. Walker, Ph.D., Assistant Professor of Economics  
Indiana University, Bloomington, Indiana 47401.

#### Problem

The effects upon consumer expenditures on ethical drugs, of the removal of patent protection, and/or compulsory generic prescribing.

#### Methods

Computer simulation of consumer expenditures on ethical drugs under assumed conditions of generic prescribing, the absence of patent protection on ethical drugs, and both. The prices used were wholesale prices published in *Drug Topics Red Book*: 1962.

#### Findings

The removal of patents on ethical drugs and the introduction of compulsory generic prescribing is estimated to reduce consumer expenditures for the 1961 mix of drugs, evaluated at 1961 prices, by approximately \$600 million per year. After allowing for a research subsidy to the industry, the net savings are estimated to be in the neighborhood of \$400 million per year.

#### Availability of Findings

The results of the study are presently available in mimeographed form, and copies may be obtained from the author. The complete study, with extensive discussion of the methodology and the data, is also available to interested persons from the author. The complete study will be published as a book by the Indiana University Press.

### 4. SELF-ADMINISTRATION OF DENTAL CARIES PREVENTIVES

#### Conducted by

Dr. Victor H. Mercer and Dr. Charles W. Gish; Division of Dental Health; Indiana State Board of Health; Department of Preventive Dentistry, Indiana University School of Dentistry.

#### Problem

Anticariogenic benefit of a therapeutic prophylaxis paste containing zirconium silicate and stannous fluoride when self-applied by groups of children under supervision. Such procedure, if found effective, could be used on a group basis in the school or community and would make possible large numbers of children receiving benefit at low cost.

#### Methods

Approximately 1500 Indiana school children presently enrolled in study program. Indices used for dental caries evaluation are DMFT (decayed, missing, filled teeth), and DMFS (surfaces). Approximately 500 children reside in a natural optimum water fluoride area and the additional 1,000 children in sub-optimum F areas. A treatment group and control group are employed and through examiners are used.

Bite-wing anterior and posterior radiographs and double blind examination techniques are used.

#### Findings

Preliminary data indicate caries reduction among those children brushing twice yearly with the therapeutic compound. This reduction is in both fluoride and non-fluoride water areas. Caries reduction figures cannot be given at this time, but are significant. Data presently does not extend beyond 1 year.

#### Availability of Findings

Data has not been published at this time. Preliminary pilot study information may be found in J. Indiana State Dental Association 46: 523, 1967.

### 5.

#### INDEPENDENT LIVING

##### Conducted by

Helen L. Scheibner; Legislative Study Committee and Indiana State Board of Health.

##### Problem

The probability of the aged regaining the ability to retain themselves on an independent basis and the reasons for dependency in the first place.

##### Methods

Survey method: hospital, nursing homes, physicians; ages, type of disability, type of care required; report available from Indiana State Board of Health.

#### IOWA

### 1.

#### A NATIONAL STUDY OF THE OPINIONS OF HOSPITAL ADMINISTRATORS ABOUT THE MEDICARE PROGRAM

##### Conducted by

Mr. Aaron Liberman of the Graduate Program in Hospital and Health Administration at the University of Iowa.

##### Problem

The primary objectives of this study were to determine (1) whether there is a lack of acceptance on the part of hospital administrators regarding the Social Security Amendments of 1965; (2) if there is, some of the reasons that might explain the lack of acceptance.

##### Methods

A national questionnaire survey was used. From a population universe of 5,882 non-federal hospitals, 588 administrators were chosen to receive the questionnaire. A stratified-random method of selection was employed. Of those selected, 286 persons submitted usable returns. For the purposes of analysis, chi-square was employed to test the sample data.

##### Findings

(1) Hospital Administrators, in general, are not satisfied with the Medicare Program as it now operates. (2) However, those sampled acknowledged that there is a definite need for such a program. (3) A statistically significant relationship was found between satisfaction with the Medicare Program and age and income of the respondent, as well as hospital size. (4) Those sampled were in opposition to an extension of Medicare's benefits to all citizens of the United States.

##### Availability of Findings

The findings of this study, *Health Care Research Series, Number Six*, may be obtained by contacting Aaron Liberman, The Graduate Program in Hospital and Health Administration, Westlawn S 517, The University of Iowa, Iowa City, Iowa 52240.

## 2. A STUDY OF PATIENT CARE INVOLVING A UNIT DOSE SYSTEM

### Conducted by

William W. Tester; University of Iowa, College of Pharmacy, and U. S. Public Health Service Grant HM-00329-04.

### Problem

(1) Unit dose packaging; (2) Design and operation of a decentralized pharmacy on the patient care area; (3) Medication errors and discrepancies under the conventional and experimental system; (4) Drug Information Service; (5) Psychological and sociological attitudes of involved professionals; (6) Economic and capacity model for evaluation; (7) Educational aspects — Nursing and Pharmacy.

### Methods

(1) Demonstration of the effectiveness of providing 24-hour drug distribution on 200 bed patient care area through the services of a full-time pharmacist in a decentralized pharmacy substation. This unit is functioning now; opened January, 1966. (2) Time and motion studies, statistical computer programs for the analysis of economic and capacity factors.

### Findings

Functioning unit dose drug distribution system provides 200 beds with medications around the clock. Study results indicate reduction of medication errors, and time spent by the nurse in medication activities. Both a manual and computer system developed for handling medication orders and data. Identification and analysis of cost and economic factors for the entire system.

### Availability of Findings

A STUDY OF PATIENT CARE INVOLVING A UNIT DOSE SYSTEM, covering the first two years of the study, available on microfilm and/or xerox copy from University Microfilm Service, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

## KANSAS

### 1. A HEARING CONSERVATION PROGRAM FOR CHILDREN IN KANSAS

(Progress Report)

### Conducted by

Gilbert Ritchey; Neurological and Sensory Disease Division, U. S. Public Health Service and Kansas State Department of Health — Maternal and Child Health.

### Problem

A demonstration project involving the schools of Kansas and the need for local Hearing Conservation Programs. Several questions will be answered as a result of the project, e.g.: (1) percentage of hearing losses in school-age children — mild-moderate-severe; (2) possible causes of hearing losses in Kansas; (3) numbers of medical facilities available; (4) Interest in Hearing Conservation Programs by schools, M.D.'s — Health Departments-and public; (5) need for Hearing Conservation Programs in schools.

### Methods

School population in Kansas.

### Findings

(1) Schools are basically interested in developing and maintaining Hearing Conservation Programs; (2) Approximately — 3% to 6% of Kansas students show hearing losses; (3) Kansans are seeing need for Hearing Conservation Programs.

### Availability of Findings

Findings will be available from sponsors.

2. MEDICAL STUDENT UTILIZATION OF GROUP PREPAID INSURANCE  
AT KUMC

(Progress Report)

Conducted by

Richard E. Easton, M.D.; BC/BS Kansas and KUMC, Depart. of Student Health Services.

Problem

Degree of enrollment and utilization patterns of health insurance by medical students and dependents.

Methods

Admissions data, chart review, cost information.

Findings

Findings available to interested individuals who are able to demonstrate a "need-to-know." Publication awaits clearance.

3. NONGROUP "FIVE OR MORE" STUDY

(Progress Report)

Conducted by

M. R. Hildman; Kansas Blue Cross-Blue Shield.

Problem

(a) By sampling means, determine the proportion of the subscribers enrolled on nongroup programs even though they are employed by an employer with five or more employees where there would normally be an opportunity for group coverage; (2) Then determine the significant differences in usage, if any, between nongroup subscribers who are self-employed or working where there are fewer than five employees and those working where there are five or more employees.

Methods

- (a) Have sampled about 2,100 subscribers by mail and have received a 97% response;
- (b) Now evaluating the significant differences in utilization.

Findings

Findings will be available after 6-1-68.

4. WICHITA OUT-PATIENT BENEFIT STUDY -- 1968

(Progress Report)

Conducted by

M. R. Hildman; Kansas Blue Shield, Kansas Blue Cross, National Association of Blue Shield Plans, Research Triangle Institute (P. O. Box 12194, Research Triangle Park, North Carolina), Blue Cross Association.

Problem

An experimental group of Blue Cross-Blue Shield subscribers in Wichita, Kansas, is being provided comprehensive out-patient benefits for up to one year to determine if there is a reduction on in-patient hospital usage of as much as 7%. A control group, which will not have comprehensive out-patient benefits available, is involved in the experiment.

Methods

Design is in final stages of completion by Research Triangle Institute on a consulting basis. The experimental group will include about 5,000 contracts and about 12,500 or more persons. In addition to the major question being investigated, there will be comprehensive analysis of how the out-patient benefits were used. (Approximate cost of experiment will be \$200,000.)

Availability of Findings

Will be available 1969-70.



5. NONGROUP PARTICIPANTS PER FAMILY CONTRACT  
(Progress Report)

Conducted by

M. R. Hildman; Kansas Blue Cross-Blue Shield.

Problem

Determine the number of persons covered by nongroup family contracts since Medicare has tended to create unknown changes in participant ratios per family contract.

Methods

- (a) Have sampled over 1,000 subscribers by mail and have received a 97% response;
- (b) Now in process of doing computer work.

Findings

Findings will be available 1968-69.

6. NONGROUP BANK DRAFT STUDY  
(Progress Report)

Conducted by

M. R. Hildman; Kansas Blue Cross-Blue Shield.

Problem

Determine whether or not there are significant utilization differences between nongroup subscribers who have elected to pay subscription charges by means of an authorization to draw a draft on the bank account as compared to nongroup subscribers who pay direct.

Methods

- (a) Identify a sample of subscribers that pays by bank draft and a sample that pays direct;
- (b) Determine if there are significant differences in utilization.

Findings

Findings will be available 1968-69.

7. HOSPITAL CHARGE TRENDS FOR BLUE CROSS PATIENTS  
AGE 65

Conducted by

M. R. Hildman; Kansas Blue Cross.

Problem

To determine current annual trends of hospital charges for patients under 65. (Post-Medicare membership on broad basic coverages).

Methods

- (a) Based on charges to Blue Cross patients;
- (b) based on hospital costs;
- (c) based on projections by hospitals.

Findings

In 1967 — Hospital charges per day to Blue Cross patients under age 65 increased at an annual rate of about 15 to 16 per cent in Kansas.  
Projected for 1968 — 10 to 12 per cent in Kansas.  
Findings available from Plan.

8. USE OF IN-PATIENT DAYS BY SUBSCRIBERS UNDER AGE 65

Conducted by

M. R. Hildman; Kansas Blue Cross.

**Problem**

The trend in use of in-patient days by subscribers under 65 since January 1, 1966 (immediate pre and post-medicare period).

**Methods**

Used Plan experience data in new EDP print-out arrangements.

**Findings**

About February, 1966, subscribers under 65 began to use fewer days of in-patient care. For Group subscribers this appears to have persisted at least through September 30, 1967. By mid-1967, the use by Nongroup subscribers had leveled off. The decrease in days used by subscribers under 65 from early 1966 to mid-1967 offset some of the abnormal increase in charges during this same period. Findings available at Plan discretion within limits and consistent with use to be made of it.

**9. ADVERTISING AND COMMUNICATIONS EFFECTIVENESS STUDY**

(Progress Report)

**Conducted by**

M. R. Hildman; Kansas Blue Cross-Blue Shield and the Marketing Research Department of BCA.

**Problem**

The principal objective is to establish some "bench marks" against which future studies can be measured in order to determine how effectively our messages are getting across to the public and subscribers.

**Methods**

Mail questionnaire to 5,500 from public at large. Mail questionnaire to 3,449 group leaders.

**Findings**

Now in process of compiling data. Findings available after June, 1968.

**10. DROP FROM GROUP STUDY****Conducted by**

M. R. Hildman; Kansas Blue Cross-Blue Shield.

**Problem**

Identify those drops from groups that might be considered controllable. Gain information on which action can be taken to reduce cancellation.

**Methods**

(1) A sample of 1,516 persons dropping group coverage and not converting; (2) Mail questionnaires to 1,004 that reason for dropping could not be determined; (3) 498 replies and 128 not deliverable; (4) Small sampling by personal interview of nonrespondents for significant differences.

**Findings**

(1) 30% to 35% of total sample would be considered controllable. (2) 40% of those responding did know how to continue coverage. (3) A majority of those changing employment will have some other coverage available to them. (4) Subscribers under age 35 are more inclined to drop Blue Cross-Blue Shield.

**Availability of Findings**

Copies of findings available from Plan.

**11. INTERNAL MIGRATION OF PHYSICIANS IN THE UNITED STATES****Conducted by**

D. C. Huff; Center for Regional Studies; University of Kansas.

**Problem**

The project represents the initial phase of a research program concerned with the general problems of the social costs and benefits associated with human migration. The specific type of migration being studied is that of physicians. The total study is divided into three parts. The first is a descriptive analysis of the net gains and losses of physicians by state over a given time span. The second is an assessment of the monetary value of such gains and losses. The third part involves formulating and testing propositions to account for the migratory patterns observed in the first phase.

**Methods**

This migratory analysis will be limited to physicians who originally received their basic medical degree (MD) from a public medical school located in the continental United States. Migratory patterns will be analyzed for different types of medical practice as well. The area unit for examining migratory patterns will be the states. The time unit of the analysis will include each year between 1930 and 1967.

**Findings**

To be published by the Center for Regional Studies.

**12. ECONOMICS OF MENTAL HEALTH****Conducted by**

Dr. Richard L. D. Morse; Department of Family Economics, Kansas Agricultural Experiment Station, O. R. 653.

**Problem**

There were three distinctly different studies providing basic family economic data useful in administering and establishing policy for mental health programs: (1) fee assessment for the farm family; (2) fee scheduling policy; (3) demand for homemaker service.

**Methods**

Initiated in 1963; closed in 1966. Three different sets of data were used: (1) farm family economic data; (2) patient termination records of Kansas community mental health centers; (3) all persons in Riley County hospitalized in 1964.

**Findings**

(1) A fee schedule form incorporating family assets and liabilities as well as income was proposed for determining ability to pay; (2) Variable fees, based on length of treatment, were proposed as having economic and therapeutic justifications; (3) Sufficient demand exists to justify establishment of a homemaker service.

**Availability of Findings**

Available from: Department of Family Economics, Justin Hall, Kansas State University, Manhattan, Kansas 66502.

**13. EFFECT ON PERCENTAGE OF OCCUPANCY OF ADULT CARE HOMES  
IN KANSAS, BY CHANGE IN BED CAPACITY DUE TO NEW CONSTRUCTION,  
ADDITIONS TO AND CONVERSION OF EXISTING FACILITIES  
AND HOME CLOSURE**

**Conducted by**

Kansas State Department of Health.

**Problem**

Was the construction of so many (86 new homes in 3 years) new homes having an effect upon the occupancy of the older homes in Kansas.

**Methods**

Occupancy study on nursing homes over a three-year period, March 1, 1962, through February 28, 1965. Patient months and bed months were calculated.

**Findings**

Bed supply increased 7.5%, utilization increased 9.1%. Older homes had a slight decline in occupancy rates.

**Availability of Findings**

Limited copies from Kansas State Dept. of Health, Medical Facilities Division, Adult Care Home Section, State Office Building, Topeka.

**KENTUCKY**

**1. A STUDY OF FAMILIES ON THE PROGRAM, OF AID TO FAMILIES WITH DEPENDENT CHILDREN AND UNEMPLOYED PARENTS IN EASTERN KENTUCKY**

**Conducted by**

William B. Clifford; Financial support for the research was supplied by the Department of Health, Education, and Welfare through the Kentucky Dept. of Economic Security, which contracted with the Social Research Service, Dept. of Sociology, to carry out the study.

**Problem**

The research objectives were to obtain data on the personal and health characteristics of the adult family members, on certain socio-economic characteristics of the family unit, and on the inter-relations of these variables. The study was a descriptive one of families in seven Eastern Kentucky counties.

**Methods**

Interviews were conducted with a 25% systematic sample of families participating in the program (AFDC-UP), using separate schedules for family heads and homemakers. The schedules were designed to secure information desired by all agencies involved. Approximately three months after the original interviews, a reinterview was carried out with a one-third systematic sample of homemakers, in five of the original seven counties. The purpose was to determine what changes had occurred, directly or indirectly resulting from the program.

**Findings**

The study families reported a high incidence of illness and chronic ailments, with  $\frac{1}{4}$  having at least one member sick in a 4-week period and 7 out of 8 families reporting one or more members with chronic ailments. Half the families reported someone with a physical impairment. Very high proportions of heads and homemakers claimed that they often had certain specified symptoms or responses that have been interpreted as indicating poor mental health. Seeing a dentist was fairly frequent, though in most cases it was for extractions rather than preventive work. A substantial portion of the bills for hospitalized family members were unpaid, for only a little more than a third of the families had their bills paid by welfare authorities, and almost none had hospital or medical insurance.

**Availability of Findings**

*Mountain Families in Poverty: Final Report* by Cyrus M. Johnson, A. Lee Coleman, and William B. Clifford, RS-29, May, 1967, may be acquired by writing: Department of Sociology, University of Kentucky, Lexington, Kentucky 40506.

**LOUISIANA**

**1. PREPAID DRUG PLANS SPONSORED BY PHARMACISTS**

**Conducted by**

Dr. Linda Pickthorne Fletcher, Associate Professor of Insurance, University of Louisiana.

**Problem**

Structure of the plans, problem areas and future of the concept.

**Methods**

Personal interviews; information from periodicals and other published material.

**Availability of Findings**

*Journal of Risk and Insurance.*

## MAINE

## 1. MIGRATION AND MENTAL DISEASE

## Conducted by

Everett S. Lee; National Institute of Mental Health.

## Problem

Migration and Mental Disease — Epidemiology of Mental Disorder.

## Methods

Hospital records used in conjunction with census data for computation of rates by age, sex, race, etc.

## Findings

Higher rates for migrants within the U. S. ; lower rates for foreign born.

## Availability of Findings

See: *Migration and Mental Disease* by Benjamin Malzberg and Everett Lee; also a number of journal articles. Work continues.

## MARYLAND

1. THE MONTGOMERY COUNTY, MARYLAND, EXPERIENCE IN  
COMMUNITY-BASED UTILIZATION REVIEW

## Conducted by

George S. Sharpe, M.D.; Medicare Coordinating Committee of the Montgomery County Medical Society, financed by a contract from the Public Health Service.

## Problem

The contract in 1967 was to "Plan for, Establish and Support Initial Operation of a Community-Based Utilization Review Plan." Included in the scope of work during 1968 are planning "ways to assist in developing and implementing policies and procedures which will promote continuity of patient care and high quality patient care," and collect and study data on utilization of extended care facilities in the County.

## Methods

The main emphasis has been establishing a program operation. The Medicare Coordinating Committee of the Medical Society is the policy making and advisory body, with an office staff consisting of a coordinator and a secretary. A roster of physicians to perform the review function has been organized. Guidelines and procedures were established for review on a sample or other basis and for review of extended duration cases. Close liaison among the Medical Society, the County Health Department, hospitals, extended care facilities and home health agencies has been developed.

## Findings

Substantial educational value to physicians who participated in review program and to those who have patients in extended care facilities. Extended care facility administrators and staff members benefited from contacts with a number of physicians representing the various specialties. Because of increased interest of physicians in developing and applying standards and policies to promote high quality patient care on a community-wide basis, there has been marked improvement in patient care. The need for the controlled flow of patients through the levels of medical care and the optimum utilization of all medical facilities have been sharply emphasized. By functioning on a community-based plan, medical judgments have tended to become crystallized and less controversial.

## Availability of Findings

"Utilization Review in Montgomery County, Maryland" by George Sharpe, M.D., and Lila H. Youngquist, B.S. October, 1967.

## 2. PROGRAM PROJECT TO STUDY THE CEREBROVASCULAR DISEASES

## Conducted by

Lewis Kuller, M.D., D.P.H.

**Problem**

Determination of the frequency of cerebrovascular disease and accuracy of diagnosis in non-traumatic deaths among Baltimore residents — age 20-64.

**Methods**

(1) A one-year stratified systematic sample of non-traumatic death certificates of Baltimore residents (20-64) obtained.

(2) After reviews of all available information including clinical evidence, it was possible to determine whether death was sudden or not and the causes of death.

**Findings**

(1) CVD was reported in 602 of the deaths for ages 40-64. (2) In only 256 instances (42.5%) was CVD listed as the underlying cause on the death certificate. (3) CVD death rates were higher in Negro females whether CVD was the principal diagnosis or was the underlying cause of death.

**Availability of Findings**

*American Journal of Epidemiology*, Vol. 86, No. 2: 442-450, 1967.

*American Journal of Public Health*, Vol. 54, No. 12, December, 1967.

### 3. GOVERNOR'S ADVISORY AD HOC HEALTH COMMITTEE

(Progress Report)

**Conducted by**

Committee of public leaders appointed by Governor of Maryland and chaired by Dr. Russell A. Nelson, President of the Johns Hopkins Hospital.

**Problem**

(1) Medicaid Financial Crisis.

(2) Overall problem of hospital costs — containment and comprehensive health planning.

**Description**

Close study of Health Dept. fiscal operations and detailed analysis of hospital inpatient and outpatient costs, physician fees, pharmacy costs, etc. Findings will be Recommendations to the Governor of Maryland.

## MASSACHUSETTS

### 1. THE RELATIONSHIP OF COST TO HOSPITAL SIZE

**Conducted by**

U. S. Public Health Service (sponsor); W. John Carr and Paul J. Feldstein (research group).

**Problem**

The primary purpose of this study was to estimate the net, or independent, effect of hospital size upon the cost of providing care. In the process, estimates of the approximate effects of a number of other factors on cost were also derived.

**Methods**

The study was undertaken by applying multiple regression analysis to data from 3,147 U. S. voluntary short-term general hospitals collected by the American Hospital Association. The variables used in the study were: total cost, hospital size, number of services provided, number of outpatient visits, whether or not the hospital had a nursing school, number of student nurses, number of different types of internship and residency programs, number of interns and residents, whether or not the hospital was affiliated with a medical school, and average wage rate.

**Findings**

Average cost per patient day falls initially as size is increased because of the economies associated with the use of specialized personnel and equipment and then probably rises at very large size levels, due to increased managerial problems of

communication and control. Apparently, the greater the capability of a hospital to provide a wide range of diversified services, the more rapidly average cost initially falls with increased size.

#### Availability of Findings

The results of this research were published in *Inquiry*, Vol. 4, No. 2, (June, 1967), 45-65. A longer (and earlier) version of the study is available from University Microfilms (HEO122).

### 2. UTILIZATION OF HEALTH RELATED SERVICES BY AGED

(Progress Report)

#### Conducted by

Morris Axelrod, Ph.D.; *Combined Jewish Philanthropies* under grant from U. S. Administration on Aging.

#### Problem

Factors relating to the utilization and non-utilization of health and other social agencies by the aged.

#### Description

Cross-section sample survey of non-institutional aged in the Boston Standard Metropolitan Statistical Area.

### 3. HOSPITAL COSTS IN MASSACHUSETTS

#### Conducted by

Mary Lee Ingbar, Ph.D.; Public Health Service Research Grant HM00190 from Division of Hospital and Medical Facilities, USPHS; Harvard University Graduate School of Public Administration (now John F. Kennedy School of Government).

#### Problem

Differences in costs of hospitals in Massachusetts in 1958, 1959, 1962, and 1963.

#### Methods

Econometric methods applied to data concerning the operation of acute short-term hospitals in Massachusetts.

#### Findings

"The typical Massachusetts general community hospital that emerges from this study is one whose costs can be effectively described by the volume and composition of its services, together with its size, level of occupancy, and internal staff structure. Up to 98% of the variation in total hospital cost among the 72 hospitals in the sample, and up to 72% when costs are expressed in terms of available bed days, can be explained."

#### Availability of Findings

Mary Lee Ingbar and Lester D. Taylor, *Hospital Costs in Massachusetts: An Econometric Study*. Harvard University Press, Cambridge, Massachusetts, 1968 (presently scheduled for May) 237 pages.

Mary Lee Ingbar, *MBROPS: Medical Economics Regression Option Programming System*. Harvard University Graduate School of Public Administration (1746 Cambridge Street, Cambridge, Mass. 02138), Cambridge, Massachusetts, 1966; 255 pages.

Mary Lee Ingbar, Barbara J. Whitney, and Lester D. Taylor, "Differences in the Costs of Nursing Service: A Statistical Study of Community Hospitals in Massachusetts," *American Journal of Public Health*, 56: 1699-1715, (October 1966).

### 4. STUDY OF THE COSTS TO A TEACHING HOSPITAL OF A PROGRAM OF CONSULTATION TO NURSING HOMES

#### Conducted by

Bruett Krusner; sponsor — Bureau of State Services, U. S. Public Health Service; research group — Social Service Department, Massachusetts General Hospital.

**Problem**

Cost to a Teaching Hospital to provide comprehensive consultative services to a preselected group of nursing homes and the economic effect of these consultative services on the homes, the effect on overall cost of participating nursing homes to deliver care, and how those costs are distributed amongst the various services.

**Description**

Comparative cost analysis: (1) Cost to the hospital calculated through time spent by personnel based upon their salaries; (2) Cost to the nursing homes based upon their audited reports to the state.

Study to be completed in March, 1969.

5. **PATIENTS, PHYSICIANS, AND THE GENERAL HOSPITAL:  
A SOCIAL SURVEY OF DECISIONS AND USE IN MASSACHUSETTS, 1960-61**

**Conducted by**

Odin W. Anderson and Paul B. Sheatsley; Center for Health Administrative Studies and National Opinion Research Center.

**Problem**

The context in which decisions are made to hospitalize surgical and medical patients — and the chain of events and decisions leading to admission and discharge.

**Methods**

Representative sample of discharges for one year in Massachusetts general hospitals — 2046 discharges and their attending and referring physicians.

**Findings**

Main finding that there is a great deal of discretion on part of physician to hospitalize from urgent to makes no difference: Surgery for 74% of the surgical admissions would have been impossible except in the hospital; treatment for 46% of the medical admissions had to take place in the hospital; and diagnostic procedures for 45% of the diagnostic admissions had to be carried out in the hospital. Source of payment — Blue Cross, private insurance, welfare, and patient paid had no influence on the proportion admitted for diagnostic tests: Blue Cross 13%; private insurance 14%; Welfare 12%; patient paid 15%.

**Availability of Findings**

Can be obtained from Center for Health Administrative Studies, University of Chicago as Research Series No. 24; \$3.00. Authors: Odin W. Anderson and Paul B. Sheatsley.

6. **AN ECONOMIC ANALYSIS OF  
THE SHORT-TERM, VOLUNTARY, GENERAL HOSPITAL**

**Conducted by**

Brackston Hinchey, Assistant Professor of Economics, Lowell Technological Institute; principal investigator only.

**Problem**

Analysis of the short-term, voluntary general hospital as an economic system engaged in the production and sale of a unique product outside the traditional context of the market. An attempt is made to apply the tools of both modern and traditional economic analysis toward the construction of an economic model.

**Methods**

Survey of the economic attitudes of hospital administrators. Survey of the literature of economics as it applies to medical care. Statistical analysis of data concerning costs and utilization of hospitals.

**Findings**

The body of traditional economic theory can be used as a foundation for an internally consistent economic model for explanation and prediction of production and distribution of services by the short-term, voluntary general hospital.



## 7. RETURNS TO SCALE IN THE PRODUCTION OF HOSPITAL SERVICES

## Conducted by

Ralph E. Berry, Jr., Assistant Professor, Harvard University.

## Problem

Whether or not hospital services are produced subject to economies of scale.

## Methods

40 groups of short-term general hospitals were formed by including hospitals with identical facilities and services and cost as a function of output was determined for each group.

## Findings

The majority of groups displayed a negative relationship between cost (average) and output lending strong support to the conclusion that hospital services are produced subject to economies of scale.

## Availability of Findings

Published in *Health Services Research*, Summer, 1967. A limited supply of reprints available from the author.

## 8. GERIATRIC REHABILITATION IN A COMMUNITY HOSPITAL

## Conducted by

Bright M. Dornblaser; U.S.P.H.S. sponsored; conducted by principal investigator at the Franklin County Public Hospital in Greenfield, Massachusetts, in association with co-principal investigators from the University of Massachusetts.

## Problem

Whether a rehabilitation program which is feasible for a community hospital could effectively rehabilitate the geriatric population being found in communities throughout the United States.

## Methods

A geriatric population in nursing homes was divided into treatment and control groups. The treatment group received treatment in the hospital rehabilitation program, and the results were compared with the control group which remained in the nursing home without special treatment.

## Findings

Activities of daily living were significantly improved. For such improvements to be maintained, hospitals need to develop social rather than medical models for their programs with its implication for follow-ups and early case findings.

## Availability of Findings

A report is pending in the form of an article in the *Journal of American Hospital Assoc.* Copies of the reports may be obtained on a loan basis c/o Director of the Franklin County Public Hospital in Greenfield, Mass.

## 9. DETERMINATION OF THE AMOUNT AND KINDS OF NURSING CARE REQUIRED BY NURSING HOME PATIENTS

## Conducted by

Mary E. Shaughnessy; Boston College, School of Nursing, Chestnut Hill, Massachusetts.

## Problem

Assessment of patients in selected nursing homes to establish specific goals for care and to determine the amount and kind of nursing services needed to achieve the goals. Data to be used in determining appropriate staffing patterns and nursing service costs.

## Methods

Identification of patient problems by observation, evaluation of A.D.L. function,

interview with patients and review of extant medical and social records. Analysis of data currently in progress.

#### 10. DEMAND FOR MEDICAL CARE FACILITIES

Conducted by

Dr. Gerald Rosenthal; USPHS — Hospital and Medical Facilities.

Problem

Relationships between characteristics (social, economic, etc.) of an area and the use of medical facilities; factors affecting the length of stay.

Methods

17,000 patient medical and financial records in New England, 1962. Sample by hospital size: uses regression analysis of variance, and factor analysis.

Findings

In addition, have completed extensive sample of 17,000 patient admissions in New England hospitals, and obtained abstracts of the medical records and the financial records. While our primary interest was in evaluating the response in terms of length of stay to differences in out-of-pocket expenditures, considerably more data are available. Also, we are evaluating movement patterns of patients and attempting to look at differences by size and type of institution with respect to the characteristics of their patients and their diagnoses.

Availability of Findings

*The Demand for General Hospital Facilities*: Monograph #14, American Hospital Association, Chicago, 1964. 101 pp.

"Factors Affecting the Utilization of Short-Term General Hospitals," *Journal of the American Public Health Association*, November, 1965.

"The Demand for General Hospital Facilities: A Principal Components Analysis," *Proceedings of the American Statistical Association*, Spring, 1965.

#### 11. DEMONSTRATION OF AUTOMATED INSTRUCTION FOR DIABETIC SELF-CARE

Conducted by

A. D. Spiegel, M.P.H.; funded by Public Health Service CH23-24-65; conducted by The Medical Foundation, Inc., Boston, Massachusetts.

Problem

Effectiveness of automated programmed instruction for diabetic self-care. Administrative methods and techniques of integrating programmed instruction into existing diabetic education programs. Staff reactions to the method of teaching patients.

Methods

Selected sample population of diabetics at various hospitals and in clinic populations. Pre and post tests on information; attitude questionnaire; observation testing with visiting nurses for behavior linkages; reading level test; IQ estimate test; staff attitude test; analysis re gains in pre and post and subjective content analysis.

Findings

Patients do learn and like learning via automated programmed instruction. Professionals need to learn how to utilize the teaching method. Much more needs to be done with administrative methods and techniques to achieve improved patient education programs.

Availability of Findings

Spiegel, A. D. Programmed Instructional Materials for Patient Education, *Journal of Medical Education* October, 1967, and others.

## 12. ANALYSIS OF A HOSPITAL AMBULANCE SERVICE

## Conducted by

L. J. Taubenhau, M.D.; USPHS (Injury Control Program) and Boston Department of Health and Hospitals.

## Problem

What is pattern of use of Boston City Hospital Ambulance Service.

## Methods

Analysis of ambulance records.

## Findings

Ambulance used more for transport of patients between hospital and other institutions than for emergency service.

## Availability of Findings

*Public Health Report*, 82: 823 (Sept.) 1967. Reprints available from Dr. L. J. Taubenhau, 818 Harrison Avenue, Boston, Mass. 02118.

## 13. EXTENDED BENEFITS CASE RESERVE REQUIREMENT ANALYSIS

(Progress Report)

## Conducted by

George E. McLean, FCAS; Research Department — BC/BS — Boston.

## Problem

For Extended Benefits contracts, to investigate the rate of reserve depletion and subsequent replacement needs, with regard to age, sex, diagnosis of claim amount.

## Description

Initially, a sample of 500 claim amounts will be explored to determine the appropriate varieties to analyze. The analysis will consist of plotting frequency and amount of claims when the data are cross-classified by age, sex, and diagnosis. Sample is in process of being selected.

14. ENROLLMENT AVERAGE FAMILY SIZE  
AGE/SEX DISTRIBUTION OF ENROLLEES

(Progress Report)

## Conducted by

George E. McLean, FACS; Research Department — BC/BS — Boston.

## Problem

To determine from a sample survey of BC/BS subscribers the average family size and the age/sex distribution.

## Description

A sample survey will be used to gather data on (at least) the age and sex of each person covered by a subscriber's contract. Project is in formation stage — historical activity on this subject is being reviewed with a view to designing a questionnaire and selecting a sample.

## 15. ANALYSIS OF HEALTH SERVICES BY GEOGRAPHIC AREA

(Progress Report)

## Conducted by

George E. McLean, FACS; Research Department — BC/BS — Boston.

## Problem

To investigate relationships among available health care facilities, health manpower, population, and economic level, in different localities.

## Description

Data consist of listings of personnel, facilities, population, and per capita income. Project is of on-going nature and preliminary findings are not yet available.

## 16. DOCTOR'S PROFILE OF OUTPATIENT PRACTICE

## Conducted by

George E. McLean, FACS; BC/BS — Massachusetts.

## Problem

General investigation of physicians' outpatient income from BS and frequency with which particular physicians perform specified procedures.

## Methods

Claim data were scrutinized to collect physician number, specialty, BS payment, and frequency of various procedures performed. Tabulations and calculations were then developed showing number of services, and service cost, tolerances with respect to doctors and their specialty areas.

## Findings

Doctors receiving the greatest outpatient income from BS were identified and cases of excessive reporting and unusual practice patterns were discovered and reported to request for further action.

## Availability of Findings

The document is confidential, and inquiries concerning it should be addressed to Dr. Charles G. Hayden.

## 17. BLUE CROSS DATA SERVICE

(Progress Report)

## Conducted by

George E. McLean, FACS; BC/BS — Boston, Massachusetts.

## Problem

Development of a Medical Record Data service similar to that provided to hospitals by HUP of Pittsburgh.

## Description

Abstracts will be submitted by participating hospital for each patient discharged. Data such as age, sex, diagnosis, length of stay, surgical procedures, complications, etc., will be included. Monthly and semi-annual summaries and listings will be generated. Appropriate statistical techniques will be utilized where indicated. Project in developmental stages. Inquiries should be directed to Mr. Roland A. McNitt, Director, Health Care Relations, Mass. Blue Cross, Inc.

## 18. PATIENT PROFILES III AND IV

## Conducted by

George E. McLean, FACS; BC/BS — Research Department — Boston, Mass.

## Problem

Frequency of admission and average hospital stay for Blue Cross patients admitted to Massachusetts participating short term general hospitals during 1965 (Patient Profiles III) and 1966 (P.P. IV).

## Methods

Blue Cross claims for each year were analyzed via data processing for each hospital-age-sex-diagnosis category, the case count, average stay and minimum and maximum tolerances ranges (one standard deviation below and above the mean) were computed.

## Findings

The most frequent diagnoses for medical, surgical, and obstetrical admissions were determined together with those with longest stay patterns. Hospital Profiles were measured against overall profiles for homogenesis hospital groups, thereby pointing up variances.

## Availability of Findings

Reports are available upon request.

19. HOME HEALTH CARE UTILIZATION PROJECT  
(Progress Report)

Conducted by

George E. McLean, FACS; BC/BS — Research Department — Boston, Mass.

Problem

An evaluation of the extent, frequency, and cost with which coordinated home health services are rendered.

Description

For each patient, diagnostic, therapeutic, and claim data, plus following information, will be supplied by the Home Health Agency with respect to these variables, at least summary tabulations will be compiled. Because of the newness of the project, the scope of the analysis is apt to be determined.

20. ECONOMIC RETURNS TO HEALTH SERVICES  
(EXPLORATORY STUDY)

Conducted by

Mount Holyoke College, Robert L. Robertson, principal investigator.

Problem

To devise methods to measure and to obtain preliminary estimates of: economic benefits of personal health services, as evidenced by the relationship of health care to time lost from work due to sickness and injury.

Methods

Each of several employee groups is divided according to health plan coverage. Within each employing organization, employees covered by one plan are compared with those covered by another as to their health care utilization and time lost from work; adjustments are made for differences in population characteristics.

Findings

Exploration indicates that employer and health plan records are promising data sources and that the general study approach appears feasible.

Availability of Findings

Conceptual and methodological issues are discussed in: Robert L. Robertson, "Issues in Measuring the Economic Effects of Personal Health Services," *Medical Care*, November-December, 1967, pp. 362-368.

21. HARD-TO-REACH FAMILIES IN A COMPREHENSIVE CARE PROGRAM

Conducted by

M. K. White, M.D.; J. J. Alpert, M.D.; and John Kosa, Ph.D.; sponsor — Medical Care Research Unit, Family Health Care Program, Harvard Medical School.

Problem

The provision of comprehensive medical care to the medically indigent with specific emphases on those who are hard to reach.

Methods

A comprehensive pediatric care program was offered to a sample of urban poor families: group one expressed interest and participated from onset; group two expressed interest but were subsequently hard to reach; group three were eligible except for their illegitimacy. Social data was obtained.

Findings

Hard-to-reach patient problems include such things as residential mobility; failure of families to keep initial appointments; ethical, cultural, and economic factors in community are such that medical care programs must adapt themselves to this environment. Hard-to-reach families can be reached if the effort is made. It is clear, however, that the time and expense involved must be considerable and that no matter what the effort some families will remain unreachable.

## 22. ON THE RELIABILITY OF FAMILY HEALTH INFORMATION

## Conducted by

M. K. White, M.D.; J. J. Alpert, M.D.; J. Kosa; and R. J. Haggerty; Medical Care Research Unit, Family Health Care Program, Harvard Medical School.

## Problem

Health care in a group of low-income families.

## Methods

Data taken from diaries of 78 Boston families from a low-income area who did not have a regular family physician. Information was recorded during a four-week period on a calendar indicating illness or other upsetting event and the action taken accordingly.

## Findings

While physical problems are well attended at need, the data suggest inadequate care for emotional problems. These families relied on public clinic care; the physician is unaware of the family health because of a lack of a continuous relationship thus exemplifying a serious obstacle to the delivery of efficient medical care. Data also indicated that only a small percentage of illnesses experienced resulted in medical contact, contrary to opinion of excess use of medical facilities by low-income patients.

## Availability of Findings

*Public Health Reports*, Vol. 82, No. 8, August, 1967.

## MICHIGAN

## 1. INVOLVEMENT OF TOP DECISION-MAKERS AS AN INSTRUMENT TO PROMOTE CHANGE IN THE ORGANIZATION AND FINANCING OF COMMUNITY HEALTH SERVICES

## Conducted by

Arthur D. Ziegler, MPH; The University of Michigan, School of Public Health, (Administrative Agency) — Michigan Department of Public Health, Michigan Health Officers Association.

## Problem

Assessment of the organization and financing of community health services in Michigan, by identified citizen leaders, toward the improvement of the present system utilized in the delivery of health services to the public.

## Methods

Citizen leaders have been organized into six regional Task Forces and a state-wide Committee of Forty to study and recommend changes for the improvement of community health services in Michigan as delivered through four component areas, e. g., Local Health Departments, Departments of State Government, Voluntary Health Agencies, and Medical Facilities and Services.

## Findings

Sixty-one recommendations on community health services have been developed by the Task Forces and the Committee of Forty. These recommendations deal with solving unmet needs in all areas of the State from the standpoint of availability and accessibility of health services, adequate financing, organizational changes to insure more efficient delivery of services and personnel staffing patterns in the administration of comprehensive programs.

## Availability of Findings

- (a) A report of the Study is to be published this spring that will be given wide distribution in Michigan and nationally.
- (b) Michigan Community Health Services Study, *Public Health Reports*, Vol. 82, No. 10, pp. 925-932, October, 1967.

2.                   PATTERNS OF SOCIAL DIFFERENTIATION BETWEEN  
                          CHA AND BLUE CROSS-BLUE SHIELD

Conducted by

The grant is furnished by the U. S. Public Health Service. The study is conducted by Charles A. Metzner and Rashid L. Bashshur, Dept. of Medical Care Org., School of Public Health, U. of M.

Problem

The general problem of the research is the differential public acceptance of prepaid group practice. The focus of this report was on the social and demographic composition of the memberships in Blue Cross-Blue Shield and the Community Health Association of Detroit, Michigan.

Methods

The data are based on two independent probability samples. Both samples were systematically drawn from membership listings of major subscriber residing in the survey area. Eligibility for sample selection in both samples was restricted to auto workers who are eligible under union contract for dual choice of health insurance currently employed by Ford, General Motors, and Chrysler.

Findings

The main findings indicate that the major appeal of prepaid group practice lies in the provision of comprehensive medical care within an optimal organizational system; centralization of major services and the geographic limitation in obtaining physicians' home services are negative factors in the choice of the group practice plan for those furthest removed from these locations; public support for innovative institutions, especially utilitarian ones, ordinarily develops under some degree of cooperation and support from the organized segments of the community.

Availability of Findings

INQUIRY, Vol. 4, No. 2, June, 1967, pp. 23-44.

3.                   CONSUMER SATISFACTION WITH GROUP PRACTICE, THE CHA CASE

Conducted by

The grant is furnished by the U. S. Public Health Service. The study is conducted by Charles A. Metzner and Rashid L. Bashshur, Dept. of Medical Care Org., School of Public Health, U. of M.

Problem

To determine extent of and factors related to consumer satisfaction with a group practice prepayment plan. Relate personal and social characteristics as well as utilization patterns to consumer satisfaction. This is the second part of the survey in which we want to draw some generalizations concerning experiences with prepaid group practice.

Methods

Data derived from a sample interview survey of automobile workers who are eligible by union contract for dual choice of health insurance, and chose the group practice prepayment plan. A probability sampling with proportionate stratification, by company and residence location, was applied to select a representative group of heads of household in the Community Health Association of Detroit, Michigan.

Findings

The data suggest increased general satisfaction with CHA as the utilization of its services are also increased. Paradoxically, the level of internal utilization is also positively related to complaints about CHA, although the majority did not complain. Outside utilization is associated with lower levels of satisfaction but may not be the cause of it. Having positive association with satisfaction are such variables as knowledge about the plan, preference for innovation as well as persons in a position of vulnerability.

Availability of Findings

*American Journal of Public Health*, Vol. 57, No. 2, November, 1967, pp. 1991-1999.

4. EVALUATION OF PROGRESSIVE PATIENT CARE AT  
MCPHERSON COMMUNITY HEALTH CENTER, HOWELL, MICHIGAN

Conducted by

John F. Griffith; The University of Michigan, W. K. Kellogg Foundation.

Problem

Organization and management of extended patient services in a small community hospital.

Methods

Studies of patient population, nursing care, costs, and the implementation of change.

Findings

Demonstrates success of a wide range of services when accompanied by sound and careful management.

Availability of Findings

The McPherson Experiment, Expanded Community Hospital Services, by John R. Griffith, Lewis E. Weeks, and James A. Sullivan, The Bureau of Hospital Administration, The University of Michigan, Ann Arbor, 1967. Available from the above. \$10. The Bureau of Hospital Administration, City Center Building — Fourth Floor, 220 East Huron Avenue, Ann Arbor, Michigan 48108.

5. BIG BILL STUDY

Conducted by

Michigan Blue Cross-Blue Shield.

Problem

A study of the effectiveness of Blue Cross-Blue Shield in meeting the total health care expenses of patients (and their families) who had large hospital bills in 1966.

Methods

Population includes all patients for whom Michigan Blue Cross paid a hospital bill of \$2,000 or more in June, 1966, being approximately 800 patients. Personal interviews are now being conducted with about half of these to obtain *total* health care expenses for the calendar year 1966 and to show portions of the bills covered by Blue Cross-Blue Shield, Medicare, other insurance, not covered, etc., by various breakdowns. Attitudes and opinions are also obtained. Similar studies were made on 1956 and 1961 samples with bills of over \$1,000.

Availability of Findings

Findings will be available on request from Research and Statistics Division, Michigan Blue Cross.

6. COSTS OF PATIENT CARE PROGRAMS IN MENTAL HOSPITALS

Conducted by

W. R. Foyle; National Institute of Mental Health.

Problem

Development of a system to determine the cost of care by "types" of patients in a mental hospital.

Methods

Professional accounting and systems work; description of patient populations by wards of patients.

Findings

Costs per day were determined by wards of patients. Variations ranged from \$3.67 to \$40.



**Availability of Findings**

Bureau of Hospital Administration, 220 East Huron Street, Ann Arbor, Michigan 48108 (University of Michigan). Limited copies available.

**7. PATIENT DISCHARGE SURVEY****Conducted by**

B. J. Drew; Greater Detroit Area Hospital Council, Inc.; financed by U.S.P.H.S. and United Foundation of Metropolitan Detroit.

**Problem**

Patient discharges (324,873) of May 1 - October 31, 1966, were included in the survey to determine place of residence and place of hospitalization. Also included data regarding physician office location, age, race, sex, and type of payment of patient, etc.

**Methods**

Source: Patient discharges reported by 89 hospitals in six-county area (representing 95% of acute general beds). Data coded to census tract.

**Findings**

Statistics reported by groups of census tracts:

- (1) Number of patients from each tract grouping whose method of payment was (a) direct pay; (b) Blue Cross; (c) commercial; (d) governmental — (any level); (e) other.
- (2) Number of patients from each hospital in each method of pay category listed in (1).

**Availability of Findings**

Data on file in the Council office. 1 (above) available; 2 (above) treated with confidentiality.

**8. ECOLOGY OF EMPLOYMENT TERMINATION**

(Progress Report)

**Conducted by**

Sidney Cobb, Program Director. Public Health Service, #CD-00102.

**Problem**

The effects of the loss of a job (and the ensuing change in job and, frequently, unemployment) on mental and physical health, and on diverse biochemical and physiological variables.

**Methods**

A longitudinal study of employed men, 35-60 years of age, who lose a job and go through the social stress of finding new employment. A control group of steadily employed men is included. Interviews in the homes of the respondents by public health nurses.

**Availability of Findings**

Cobb, S., Brooks, G. W., Kasl, S. V., and Connelly, W. E.: The Health of People Changing Jobs: A Description of a Longitudinal Study, 56:1476-1481, Sept., 1966.

**9. MEDICAL CARE OF THE VERY AGED**

(Progress Report)

**Conducted by**

Arthur H. Richardson; Heller Graduate School at Brandeis University with the Michigan Health and Social Security Research Institute (grant from Division of Community Health, USPHS).

**Problem**

A social change study, utilizing panel interviews and medical records, of the medical care of a very old population. The investigation will provide data on the use of

medical care resources by retired United Auto Workers living in Michigan and describe the nature and scope of changes that occur in use by these retirees before and after implementation of Medicare and a new union medical care benefit program.

#### Methods

50% random sample of U.A.W. retirees living in Michigan. Data gathered from interviews and record sources at 2 points in time, before and after implementation of new health plans.

#### Availability of Findings

Initial findings will be available for distribution in the fall of this year.

### 10. DEMAND FOR HEALTH INSURANCE COVERAGE IN A METROPOLITAN POPULATION

#### Conducted by

Rashid L. Bashshur, Ph.D., and Charles A. Metzner, Ph.D.; University of Michigan, School of Public Health supported by PHS grant NIH 1 SO1 Fr 5447-04.

#### Problem

Public views toward health insurance coverage and public demand for various benefits under a system of prepayment.

#### Methods

931 interviews representing members of the United Auto Workers and the adult population of Metropolitan Detroit.

#### Findings

Importance of insurance coverage was judged high by many people and outran both availability and ability to pay for it. A majority wanted insurance covering hospitalization, surgical services, medical services in hospital, home and office, drugs, dental services, home nursing, checkups and inoculations.

#### Availability of Findings

*Public Health Report*, Vol. 83, No. 1, January, 1968.

### MINNESOTA

#### 1. VALUE OF DEMOGRAPHIC AND SOCIAL DATA TO HOSPITALS (Progress Report)

#### Conducted by

E. Gartly Jaco, Ph.D.; Division of Hospitals and Health Care Facilities, U. S. Public Health Service, HEW Dept.

#### Problem

Obtain demographic and socio-economic characteristics of patients admitted to acute general hospitals in a large metropolitan area and together with data from admitting hospitals and physicians, determine factors of patients, physicians and hospitals that may be related to differential rates of admission and length of stay.

#### Methods

10% sample of all patients admitted to all general acute hospitals for a 2-year period for the Minneapolis, Minn., metropolitan area. Data obtained during admission processing, during stay, and at time of discharge. Multivariate statistical analysis is planned to delineate variables related to different rates of hospital usage, i.e., admission and length of stay.

#### Availability of Findings

When reports become available during this year (1968), interested persons may write: Prof. E. Gartly Jaco, Dept. of Sociology, University of California, Riverside, Calif. 92502, who is principal investigator of this study.

2. "MODERN MEDICINE" POLL OF MEDICAL PRACTICE  
CANCER OF THE BREAST

Conducted by

Wyman E. Jacobson, M.D.; Modern Medicine Publications.

Problem

Among U. S. physicians in active practice, to learn their exact treatment(s) used in their most recent patient with cancer of the breast, including surgical procedures, radiation, hormones, and chemotherapy plus any other important treatment.

Methods

A short questionnaire was sent with the May 8, 1967, issue of Modern Medicine, asking readers to respond telling us what's going on in treatment of cancer of the breast. The poll drew 14,463 usable returns, about 8% of the practicing physician population, closely paralleling the regional distribution of all doctors.

Findings

Leading operative procedures were:		Among the 8,970 (or 62%) who reported treating the disease: leading combination treatments were—
Radical mastectomy	73.3%	Radical mastectomy plus radiation
Simple mastectomy	16.4%	Radical mastectomy only
Oophorectomy	13.1%	Radical plus radiation plus one or more other treatments
Other treatment used:		
Radiation, X-ray or cobalt	58.2%	
Androgens	11.4%	
Estrogens	8.4%	
Chemotherapy	13.4%	

3. A DEMONSTRATION OF REDUCING HOSPITAL OPERATING COSTS  
BY THE SHARING OF SERVICES

(Progress Report)

Conducted by

E. Gartly Jaco, Ph.D.; USPHS, Division of Hospital and Medical Facilities.

Problem

To demonstrate that voluntary acute general hospitals can reduce or at least hold the line on operating costs by the sharing of services with other hospitals, and to evaluate any savings as accurately as possible.

Methods

Five voluntary acute general hospitals in the city of Minneapolis, Minnesota, are the major hospitals involved, with several other general hospitals participating in the sharing of certain services at different times. A feasibility study initiates sharing action, with one hospital serving as a "control" hospital who will not share that particular service during the study-period which varies with each service involved. Costs to operate such services are measured and compared to the experimental (sharing) hospitals and the non-sharing control hospital. Evaluation of the service's quality also included in the appraisal of any effects due to sharing.

Findings

Feasibility studies have indicated potential savings in the sharing of laundry and linens, printing of basic forms, bad debt collections, joint purchasing and central storage, dietary and meal preparations, drug purchasing, with others also being considered. Preliminary steps have been initiated to share most of these services and are actually in operation. Sharing of services still in evaluation stages. Final evaluation still to be conducted as sharing of each service completes its study-period. (Project still has another year and a half to go before completion.)

Availability of Findings

Progress reports available on early stage of overall project. Final report should be available in early Fall of 1969. Reports available from either Dr. E. G. Jaco, Dept. of Sociology, University of California, Riverside, California 92502, initial principal investigator of project and now consultant; or from Dr. T. J. Litman, School of Public Health, Program in Hospital Administration, University of Minnesota Medical Center, Minneapolis, Minnesota 55455, now principal investigator.

4. A STUDY OF THE UNIVERSITY OF MINNESOTA HOSPITAL  
DRUG DISTRIBUTION

Conducted by

Hugh F. Kabat, Ph.D.; College of Pharmacy, University of Minnesota.

Problem

The flow of prescription orders to pharmacy and the returns to nursing care units with lapsed time at each stage.

Methods

32 nursing units: routine and stat (immediate) prescriptions. Transcriptions stamped on preparation, upon receipt at pharmacy, upon completion in pharmacy, and upon arrival at the nursing unit.

Findings

Stat orders exceeded routine due to failure of system. Deliveries poorly spaced. Time in pharmacy abnormally long. Starter doses needed to relieve pressure.

Availability of Findings

Report to University of Minnesota Hospital Administration. AJHP, Vol. 24, May 1967, pp. 263-268.

5. HEALTH CARE AND THE FAMILY:  
A THREE GENERATION STUDY

Conducted by

USPHS: Division Community Health Services, University of Minnesota: School of Public Health (Prog. in Hosp. Admin.)

Problem

Survey of the health care experiences, reactions, decision making processes, attitudes and opinions of a sample of three generational families in the Twin City Area; data include attitudinal and opinion materials, drug, hospital, physician-dentist utilization, marital integration and family activity measures, family budget information including coverage and selection of health insurance coverage.

Methods

A sample of 67 three generation family triads all living within a 50-150 mile radius of the Twin Cities was selected for study. Each family (parent, grandparent and married children) were interviewed quarterly by a trained interviewer. A total of 210 families participated in the study. Data is presently being coded and transferred to IBM cards. Computer programs and runs are planned for this spring.

Availability of Findings

To be published in various social and medical care journals as soon as data is available. The possibility of a monograph on family response to health and health care services is being contemplated.

6. A STUDY OF THE PATIENT PATTERN OF  
PAYMENT BY MEDICAL SPECIALTY

Conducted by

James R. Petersdorf; University of Minnesota, Program in Hospital Administration, Master's thesis.

Problem

To determine if there was a relationship between patients' accounts over six months old and the medical specialty that admitted the patient.

Methods

Analyzed all accounts of patients discharged between January 1, 1963, and June 30, 1963.

Findings

(1) The medical specialties of General Practice, Neurosurgery, Orthopedic Surgery,

Plastic Surgery, and Urology had a higher percentage of total charges unpaid after six months than the average of all medical specialties combined. (2) The medical specialty of General Practice has a higher percentage of total charges unpaid after six months in the Obstetrical Service than the Obstetrics-Gynecology medical specialty. (3) The Age Groups 15-34 and 35-49 years have the highest percentage of total charges unpaid after six months when all the medical specialties are combined. (4) Patients who have Blue Cross have the smallest percentage of total charges unpaid after six months of all patients when compared with other types of third party payers. (5) Certain medical specialties do have a relationship to patients with charges unpaid after six months. (6) Certain patient groups within medical specialties will have a higher percentage of total charges unpaid after six months than will other patient groups within medical specialties when these patient groups are compared with all patients. (7) A repeat of this study as well as studies dealing with other variables in the area of medical specialties are suggested.

#### Availability of Findings

10-day loan from: Program in Hospital Administration, University of Minn., 1260 Mayo Memorial Building, Minneapolis, Minnesota 55455. Copies available from: University Microfilms, Inc., 300 North Zeeb Road, Ann Arbor, Michigan 48106.

### 7. PROVISIONS FOR PHARMACEUTICAL SERVICES IN SMALL MINNESOTA HOSPITALS

#### Conducted by

Henry W. Winship III and Hugh F. Kabat, Ph.D.

#### Problem

To determine the origins, extent, and methods used to provide professional pharmacy service to the small hospitals in Minnesota.

#### Methods

- (1) Selection of 12 pharmacists providing part-time professional pharmacy service.
- (2) Interviews with pharmacists and administrators re type of pharmacy service provided.

#### Findings

- (1) On-site service by pharmacists noted in 8 of the 12 hospitals studied.
- (2) The presence of the pharmacist in the hospital environment greatly increases the effectiveness and range of pharmacy service.

#### Availability of Findings

- (1) Guide Issue, Part 2, Hospitals, J.A.H.A. 39: 450 Aug. 1, 1965.
- (2) Mirror to Hospital Pharmacy (Easton, Pa., 1964) p. 169.

### 8. APPLICATION OF AUTOMATIC DATA PROCESSING EQUIPMENT TO THE CONTROL OF RESTRICTED DRUGS IN THE HOSPITAL

#### Conducted by

Minneapolis Veterans Administration Hospital: Charles F. Richards, M.S.; Hugh F. Kabat, Ph.D.

#### Problem

Maintaining the necessary dangerous and habit-forming drug control records consumed the professional services of one pharmacist for eight hours per month.

#### Methods

Expensive professional services were being utilized to maintain a largely routine clerical record system. A search was made for alternate methods of maintaining these records.

#### Findings

The services of a professional pharmacist were used for less than one hour per month under the new system.

#### Availability of Findings

AJHP, Vol. 21, p. 377.

## 9. MEDICAL AUDITING IN A COMPREHENSIVE CLINIC PROGRAM

## Conducted by

Graham Beaumont, M.B., F.R.C.P., et al.; University of Minnesota Comprehensive Clinic Program.

## Problem

Outpatient care quality.

## Methods

A staff and medical student chart audit of outpatients seen in a referral center. Charts were compared with criteria for acceptable care. *Journal of Medical Education*, Vol. 42, No. 4, April, 1967.

## Findings

Of 250 charts, 39% of patients have faults in care.

## MISSOURI

## 1. THE SERVICE MANAGER SYSTEM: NURSE EFFICACY AND COST

## Conducted by

J. V. McKenna; United States Public Health Service, Grant No. NU-00170-03. From the Division of Nursing, Bureau of State Services Community Health.

## Problem

Compare traditionally organized nursing units to service managed nursing units with respect to (a) activities of all personnel, (b) patient welfare, and (c) cost.

## Methods

Direct comparison between a service managed medical unit and a traditionally managed medical unit; between a service managed surgical unit. Activity comparisons by work sampling. Patient welfare by nine Patient Welfare Scales; actual costs from the Accounting Department.

## Findings

Tentatively, service management appears to provide nurses more time for direct patient care which is reflected in improved patient welfare. Service management appears to be slightly more costly but the improvement may be worth the additional costs.

## Availability of Findings

(1) "Content Validation of a Nursing Practice Evaluative Instrument." Brodt, Dagmar E. & Ellen H. Anderson. *Nursing Research* 16:2 (Spring 1967) p. 167. (2) "Work Sampling on a Nursing Unit: Observations at Equal Time Intervals Versus Random Observations." Fogarty, Donald W. & Joseph V. McKenna. *Nursing Research*. 16:4 (Fall, 1967) p. 371. (3) The Service Manager System: Nurse Efficacy and Cost: Second Year Progress Report June 1, 1966 to May 31, 1967, McKenna, Joseph V. Abstract and full report available from University Microfilms, Inc. (Division of Xerox Corp.) 300 North Zeeb Road, Ann Arbor, Michigan 48106.

2. HOSPITAL EMPLOYEE GROUP PLAN UTILIZATION OF  
IN-PATIENT SERVICE AT PLACE OF EMPLOYMENT VS. OTHER HOSPITAL

(Progress Report)

## Conducted by

Richard E. Easton, M.D.; BC/BS, Kansas City, Missouri, and University of Kansas Medical Center, Department of Preventive Medicine, Department of Employee Health Services.

## Problem

Comparative utilization of coverage at KUMC vs. outside hospitals; Chart review (utilization review) to determine number of excess hospital bed days due to requirement that patients be hospitalized to receive payment.

**Methods**

BC/BS data from K.C., MO., BC/BS main office and KUMC Admissions records and medical charts; KUMC Employee population (200 admission is congruent to 100/year); cost and type of charge data, LOS value judgment on need for hospitalization and possibly physician and/or patient structured interviews.

**Availability of Findings**

Available to interested individuals who are able to demonstrate a "need-to-know." Publication will require clearance and has not been determined as yet.

**3. COST FACTORS IN A HOSPITAL-BASED HOME CARE PROGRAM**

**Conducted by**

David A. Gee; The Jewish Hospital of St. Louis.

**Problem**

Comparative factors influencing costs in hospital-based, comprehensive home care programs.

**Methods**

Cost data derived from publications, questionnaires, personal interviews.

**Findings**

While cost per home care day, within a wide variety of home care programs, is similar, cost per visit and cost per total length of stay vary considerably, dependent upon the organization and scope of the home care program. In general, community-based, VNA programs tend to have the lowest cost per length of stay; whereas, hospital-based programs, dealing primarily with indigent patients, have the highest cost.

**Availability of Findings**

"Cost Factors in a Hospital-Based Home Care Program," *Inquiry*, Vol. IV, No. 3, October, 1967, Chicago: Blue Cross Association.

**4. RELATIVE VALUE SERVICE STUDY 1968**

(Optometry)

**Conducted by**

George M. Milkie, O.D.; American Optometric Association.

**Problem**

Relative values of optometric service.

**Methods**

By survey and evaluation, defined professional optometric services and determined relative values thereof.

**Availability of Findings**

Available from American Optometric Assn., 7000 Chippewa St., St. Louis, Mo. 63119.

**NEBRASKA**

**1. MEDICAL EXPENSE AS A FACTOR IN BANKRUPTCY**

**Conducted by**

Mr. Jerrold Strasheim, Referee in Bankruptcy.

**Problem**

To ascertain the extent to which medical expense contributed to bankruptcy.

**Methods**

- (1) Review of Bankruptcy files — 1965 — Omaha, Nebraska;
- (2) Interviews with Bankrupts to determine their personal views regarding the impact of Medical Expense.

**Findings**

- (1) Total indebtedness of all petitions filed in Nebraska was \$7,744,848.65 of which \$333,628.70 or 4.3% represented medical expense.
- (2) Average total involvement amounted to \$11,032.44; of this \$10,557.29 was non-medical and \$586.34 medical.
- (3) Medical Expense did not appear to play a major role in the overall picture of bankruptcy.

**Availability of Findings**

*Nebraska State Medical Journal*, Sept. 1967, Vol. 52, No. 9, p. 412.

**NEW JERSEY**

1. RESEARCH AND CHARACTERISTICS OF PATIENTS AT  
NEW JERSEY GENERAL HOSPITALS

**Conducted by**

L. D. Nierenberg; Health Facilities Planning Council for New Jersey.

**Problem**

Short-term Hospital Patient origin and selected characteristics.

**Methods**

Survey of general hospitals in the State.

**Findings**

Residence of patients as guide to delineation of health planning area.

**Availability of Findings**

Available on request from Health Facilities Planning Council.

2. PHYSICIAN SPECIALTY AND AGE, New Jersey 1967

**Conducted by**

L. D. Nierenberg; Health Facilities Planning Council for New Jersey.

**Problem**

Supply of Physicians in New Jersey.

**Methods**

Compilation of M.D. & D. O.'s by Age, Specialty, and Location.

**Findings**

Variations in numbers of physicians in different parts of the State.

**Availability of Findings**

Available from Health Facilities Planning Council for New Jersey on request.

**NEW YORK**

1. EVALUATION OF IMPACT OF 1965 SOCIAL SECURITY AMENDMENTS  
ON DISTRIBUTION OF MEDICAL SERVICES

(Progress Report)

**Conducted by**

Leonard S. Rosenfeld, M.D.; Medical Services Division, Health and Hospital Planning Council of Southern New York, Inc.

**Problem**

Effects of programs instituted under provisions of Titles XVIII and XIX of the Social Security Act Amendments of 1965 on the distribution of medical services according to age, socio-economic status, and area of residence.



**Methods**

The study is being developed in three parts designed to accumulate information by age, socio-economic and geographic distribution on utilization of selected services before and after the inauguration of services under the Social Security Amendments.

(a) For home health services provided by hospital-based organized home care programs and by Visiting Nurse Services, information was accumulated in the form of a one-day census of patients of these agencies, of discharges during the period of a month and of the utilization of selected services during the month of April, 1966. A similar study will be conducted in April, 1968. (b) For services of long-term care facilities in 1966 and in 1968 employing similar methods to those outlined under (a) above. (c) For medical, hospital, and dental services, on the basis of data collected by the Population Health Survey, conducted under the auspices of the Center for Social Research of the City University of New York.

**Findings**

Base-line studies for 1966 have been completed. Two reports have been published on the base-line studies, one on distribution of home health services and another on long-term care facilities. Other reports are in preparation. Final reports of findings must await completion of the second phase of the study being conducted in 1968.

**Availability of Findings**

(a) "Pre-Medicare Utilization of Home Health Services in a Metropolitan Area," *Medical Care*, V pp. 85-99 (March-April) 1967. (b) Health and Hospital Planning Council of Southern New York, Inc., *Survey of Long-Term Care Facilities in Southern New York*, December, 1967.

**2. AMBULATORY CARE SERVICES IN NEW YORK CITY****Conducted by**

Leonard S. Rosenfeld, M.D.; Medical Services Division, Health and Hospital Planning Council of Southern New York, Inc.

**Problem**

Description of selected characteristics of ambulatory care services provided through hospital-based ambulatory clinic facilities in New York City.

**Methods**

Ten hospital-based ambulatory care facilities representing variations in auspices, size, and geographic location were selected for study. Concurrent studies were conducted in the following areas: (a) organization; (b) patient load and staff; (c) nursing functions and the distribution of nursing responsibility among several categories of personnel; (d) survey of patient opinions, attitudes, and patterns of utilization of services.

**Findings**

Wide variations in virtually all attributes of ambulatory care. In general these variations are below a level that would be considered adequate in terms of current concepts and practices. There is little evidence of application of any system of standards or concepts of nursing practice in nursing services in ambulatory facilities. In spite of this, however, the predominance of opinion among users of these services indicates patient satisfaction.

**Availability of Findings**

(a) Kresky, B. K. and Rosenfeld, L. S. *Ambulatory Clinic Care in New York City*, Paper presented before Medical Care Section at the Annual Meeting of the American Public Health Association, October, 1967. (b) Working Papers on various aspects of the study being prepared for publication.

**3. HOSPITAL STAFF APPOINTMENTS**

(Progress Report)

**Conducted by**

Leonard S. Rosenfeld, M.D.; Medical Services Division, Health and Hospital Planning Council of Southern New York, Inc.

**Problem**

Distribution of hospital staff appointments and of various levels of staff responsibility according to personal and professional characteristics of physicians and according to their location of practice in the 14-county area of the Southern New York region.

**Methods**

A complete roster of physicians practicing in the region including data concerning their characteristics in accordance with the requirements of the study. Being added to these data are data received from hospitals concerning identity of physicians on medical staffs and level of staff responsibility. These data will be analyzed to indicate the factors of selection that are at work with regard to hospital appointment to medical staff positions. Also to be studied are staffing norms of the several types of institutions and geographic distribution of physicians according to professional and personal characteristics.

4. **ASSIGNMENT OF PUBLIC HEALTH NURSES TO  
ACUTE GENERAL HOSPITALS TO PLAN FOR CARE AFTER DISCHARGE**

**Conducted by**

Margaret Rathburn, M.D.; Monroe County Dept. of Health; U. S. Public Health Service.

**Problem**

Whether the assignment of a public health nurse clinician to a general hospital can help in the predischARGE planning for the patient.

**Methods**

Two nurses assigned to each of two hospitals. One nurse collected data and did discharge planning. Second nurse collected data only in second hospital. Nurses reversed in hospitals after one year. Diabetes, cancer of head, neck, colon and breast, congestive heart failure, major fractures (back or hip), leg amputation, cerebral vascular accidents. Follow-up of discharged patient at one and three months after discharge.

**Findings**

Statistically, little-no reduction in patient stay. Subjective program welcomed by both hospitals who asked for its continuance after end of study. Service has since been extended to two other hospitals.

**Availability of Findings**

Dr. Margaret Rathburn, Monroe County Dept. of Health, Rochester, New York.

5. **THE THREE "R'S" OF PSYCHIATRIC TREATMENT STATISTICS**

**Conducted by**

Abbot S. Weinstein; New York State Department of Mental Hygiene, Office of Statistics and Data Processing, and Rockland Research Center, Information Sciences Division.

**Problem**

To develop automated systems involving a single input to medical records, statistical reporting, and psychiatric case registers. This system is for use in all psychiatric facilities serving a given geographic area.

**Methods**

Information needed to make decisions about the treatment of individual psychiatric patients and to plan, operate and evaluate treatment programs is being identified. Technical procedures for recording, processing and using this information are being developed.

**Findings**

The logical inter-relationship of psychiatric medical records, statistical reporting and psychiatric case registers is discussed. It is shown that all three are logically parts of a single system, with the medical record the foundation from which information is drawn for individual patients and for groups of patients. An example

is presented showing how a patient progress note is initiated by the computer, completed by the physician who enters machine-readable marks on a structured form, the form then being entered into an optical reading machine leading to the computer which prints out narrative style record copy and statistical tabulations.

#### Availability of Findings

Available from Mr. Abbot S. Weinstein, Director of Statistics and Processing, New York Dept. of Mental Hygiene, 256 Washington Avenue, Albany, New York.

#### 6. AN ANALYSIS OF HEALTH INSURANCE EXPERIENCE AND THE USE OF A DIAGNOSTIC AND ADVICE CENTER BY THIRTEEN WELFARE FUNDS

##### Conducted by

Mildred A. Morehead, M.D.; Teamster Joint Council No. 16 and Management Hospitalization Trust Fund.

##### Problem

Utilization of hospital and physician insurance.

##### Methods

Based on data submitted by Blue Cross, Health Insurance Plan of Greater New York and Group Health Insurance, Inc. This type of report is prepared annually. The first annual report of the Comprehensive Care Program will be completed in the near future.

##### Findings

Hospitalization rate has remained fairly constant over the years. No improvement in type of hospitals used or qualifications of surgeons selected.

#### Availability of Findings

On request.

#### 7. REPORT OF INTERVIEWS WITH SELECTED TEAMSTER FAMILIES: ATTITUDES, UTILIZATION AND OUT-OF-POCKET COSTS FOR HEALTH STUDIES

##### Conducted by

Anne Zanes, Project Director; Mildred A. Morehead, M.D., M.P.H., Director; Rose Donaldson, M.S., Statistician; Teamster Joint Council No. 16 and Management Hospitalization Trust Fund, Montefiore Hospital and Columbia University School of Public Health and Administration.

##### Problem

To demonstrate the value of a high quality hospital-based group medical care program, the Teamster Labor Management Fund set up the Teamster comprehensive Care Program (TCP) at Montefiore Hospital in July, 1966. The program offered complete coverage for medical and dental services. A survey was made among those who joined TCP and those who decided not to, to compare their attitudes, medical conditions, costs and utilization for the year prior to the opening of TCP.

##### Methods

A household interview study was conducted among families who joined TCP and those who declined. An extensive questionnaire was used in which data was collected on the utilization of health services and out-of-pocket costs for each family member in the sample.

##### Findings

It had been hypothesized that the self-selected families who joined TCP would be higher utilizers of medical and dental services and would have high out-of-pocket costs for such care than those families who declined to participate. This was not found to be the case. Expenses for health services, physician utilizations and hospitalization rates were not higher for the families who joined the program. Some differences between the families were noted in their attitude about health care, the degree of attachment to a present provider of service, their reported health practices and, to a certain extent, the nature of their identification with the union.

**Availability of Findings**

Requests may be made to: Medical Audit Unit, Columbia University School of Public Health and Administration, 630 West 168th Street, New York, New York.

**8. HEALTH REFERRAL SERVICE FOR ARMED FORCES REJECTEES****Conducted by**

Jules E. Vandow, M.D.; New York City Department of Health.

**Problem**

To determine how men rejected for military service because of medical conditions could effectively be referred to appropriate sources of care.

**Methods**

Young men rejected for military service at the N.Y.C. Armed Forces Examining Station (AFES) were interviewed and randomly selected for medical counseling, either immediate (1/3) or delayed counseling at various locations (2/3). The study yields data on the characteristics of the rejectee population, their needs for medical care, their responses to the referral program, and information on the services available in the community to meet the needs of the rejectees.

**Findings**

The study indicated a distinct need for a medical counseling and referral service for military rejectees and demonstrated that such a service program is feasible. The results suggested a need for additional trials to improve the motivation of these young men to seek medical care and to help identify those most likely to follow the recommendations of the counselor.

**Availability of Findings**

"Health Referral Services for Armed Forces Rejectees," *Public Health Reports*, Vol. 82, No. 4, April, 1967. pp. 305-322.

**9. WESTERN NEW YORK INVENTORY OF COMMUNITY HEALTH SERVICES FOR CARDIOVASCULAR DISEASE****Conducted by**

Harry A. Sultz, DDS; Bureau of Heart Disease, Division of Chronic Disease Service, State of New York Department of Health.

**Problem**

To devise a comprehensive list of on-going community services concerned with the prevention and management of cardiovascular disease; to ascertain which types of information describing these services could be obtained on local, state, and national levels through mailed, self-administered questionnaires; to determine the comparability of information obtained from a wide range of sources by mailed questionnaires with that obtained by interview methods; to develop, for the purpose of local, state and national surveys, a list of official and voluntary agencies providing these services.

**Methods**

Development of a list of services appropriate to a predetermined list of diagnostic categories; compilation of a list of the official and voluntary agencies which provide these services. Contact and interviews of representatives of the agencies in selected areas, and revision and completion of lists of services and agencies on the basis of the collected data.

**Findings**

The development of a questionnaire which can be applied in other areas, and an assessment of services available in Western New York. In this connection, it was found that this survey technique is most effective in determining those services which are not available rather than describing those that do exist, and has uncovered significant deficiencies in the health services available to the population of Western New York.

**Availability of Findings**

Harry A. Sultz, DDS, Clinical Associate Professor of Medicine, State University at Buffalo.

10. A DESCRIPTION OF THE BARRIERS TO EMPLOYMENT FACED  
BY PERSONS WITH CARDIAC DISEASE

Conducted by

This study was sponsored by the Bureau of Heart Disease, New York State Department of Health. The study was conducted by the Staff, Cardiac Rehabilitation Project, Syracuse University and Upstate Medical Center, A. C. Higgins, Ph.D., Director.

Problem

This was an exploratory study having as its object a determination of the barriers to re-employment, if any, faced by persons who had myocardial infarctions. Administrative, medical, economic, psychological, legal and sociocultural factors were examined for their effects on re-employment.

Methods

The design included: (1) an extensive review of the literature dealing with rehabilitation of patients with cardiovascular disease; (2) interviews were conducted with "knowledgeable people" throughout the State of New York — including insurance carriers' executives, lawyers, physicians, union representatives, employers, and others designated as relevant; (3) a sample of Syracusans who had survived their own infarcts were interviewed to determine their experiences in returning to work; (4) a special study of the Syracuse Work Evaluation Unit was conducted to determine its relationships to physicians in private practice in the community.

Findings

The vast majority of patients in Syracuse (80%) who met the study criteria had no major difficulties in returning to work. There has been a great deal of talk and a lot of argument about the problems of rehabilitation of cardiac patients, but most of the talk is just that. Physicians, for reasons of their own, contribute to the difficulties faced by patients and any attempt to help patients must begin with efforts directed at physicians and designed to improve the kind of services physicians can render to a community.

Availability of Findings

"The Re-employment of Patients Who Have Had Myocardial Infarction, Syracuse, New York," *American Journal of Public Health*, February, 1968. "The Specialty Clinic: Some Organizational Problems in Providing for Health Facilities," forthcoming. A limited number of copies of the Final Report of the Project (mimeographed) are still available.

11. COMPREHENSIVE AND PROLONGED BEDSIDE CARE

Conducted by

L. A. Walfrand; Blue Shield of Western New York, Inc.

Problem

The feasibility of including Comprehensive Care and Prolonged Bedside Care in our health coverage.

Methods

These benefits were assigned specific codes and an analysis of the use under these codes was made. During the study period from November, 1966, through October, 1967, there were 6,934,248 member months of exposure which produced incurred claims valued at \$25,000 or \$.0036 per member per month for Prolonged Bedside Care. The Comprehensive Care program produced a claim amount of \$17,000 or \$.0025 per member per month.

Findings

Prolonged Bedside Care proved to be not unduly costly and hospital records are available to certify that this service was rendered. Even though Comprehensive Care indicated it was not unduly costly, this program has been discontinued because of the inability to adequately control utilization as all hospitals are not able to provide reports to substantiate whether care of this nature had been rendered.

## 12. A STUDY OF MOTIVATIONAL FACTORS IN NURSING HOME PATIENTS

(Progress Report)

## Conducted by

Monroe Mitchel; The A. Holly Patterson Home for Nassau County Aged & Infirm in cooperation with the Department of Psychology, Hofstra University, Hempstead, N. Y.

## Problem

To study the impact and significance of motivational activities on a nursing home population.

## Methods

Psychological testing procedures designed by the Hofstra University Psychology Department.

## 13. USE AND COST OF A.H.S. COORDINATED HOME CARE PROGRAMS

## Conducted by

Joseph B. Stiefel, M.D.; Associated Hospital Service of New York, 80 Lexington Avenue, New York, New York.

## Problem

Use and costs of hospital-based coordinated home care by AHS subscribers — initial impact of Medicare.

## Methods

Tabulation of AHS subscriber home care cases, 1960-1967. Detailed study of first 5,000 pre-Medicare AHS home care cases re: length of in-patient and home care stays by age groups, diagnoses, costs of in-patient care and home care, reductions in hospital stays. Tabulations of number of programs and AHS home care patients, 1960-1967.

## Findings

During the period between March, 1960 and March 1964, in-patient care of AHS home care patients increased from \$615 to \$850 per case; home care per case costs increased from \$175 to \$244, but ratio of per case home care costs to preceding in-patient per case costs progressively decreased.

## Availability of Findings

"Use and Cost of AHS Coordinated Home Care Programs," by Joseph B. Stiefel, M.D., Blue Cross Association, *BCA Inquiry*, October 1967, Vol. IV, No. 3, pp. 61/68. This paper was prepared at the request of Blue Cross Association for a brief article on use and costs of AHS home care. Detailed study of AHS Post-Medicare Home Care Experience is pending.

## 14. DRUG UTILIZATION AND COSTS FOR PATIENTS

WITH ACUTE MYOCARDIAL INFARCTION

## Conducted by

Charlotte Muller, Principal Investigator; Columbia University School of Public Health and Administrative Medicine.

## Problem

Utilization and cost of drugs in a hospital setting — variety, number per patient, route, therapeutic purpose, use of generic names, time distribution during hospital stay were aspects of utilization under study. Drugs are of concern in relation to quality of medical care, hospital costs, and the response of medical care professionals and institutions to new technology.

## Methods

Patients with a single diagnosis were studied, the better to compare public and voluntary large teaching and small community institutions. Records 25 patients in each of 4 hospitals were followed from time of first admission for 3 months. Medical charts were used for drug data, pharmacy records and city purchasing data for drug prices.

**Findings**

There are many differences in drug use and cost between and within hospitals. Some of these are due to the greater severity of the illness in city hospital patients. The number of drugs per patient/day was greatest in the small city hospital, which had the sickest patients. 176 drugs were used at least once, but 33 drugs were used more frequently than others. Generic prescribing made up over 50% of drug orders in all but the small voluntary hospital, which had the highest drug costs. Use of comfort drugs was small in city hospitals and there were other differences in "style." Cost per admission centered around \$13.

**Availability of Findings**

Published in *Health Services Research*, Spring, 1967. Senior author has reprints. (Now at City University of New York, Graduate Center, 33 West 42nd Street, Rm. 1124, New York, N. Y. 10036).

15. AN EVALUATION OF OBSERVER VARIABILITY IN A HOSPITAL  
BED UTILIZATION STUDY

**Conducted by**

James G. Zimmer, M.D.; Department of Preventive Medicine and Community Health, University of Rochester School of Medicine.

**Problem**

- (a) Methodology of Hospital Bed Utilization Review.
- (b) Description and analysis of observer reliability in utilization review.
- (c) Determinants of misutilization of hospital beds.

**Methods**

Probability sample studies of hospital inpatients using multiple observers with statistical analysis of results and development of a mathematical model to describe the observer variability and its implications for utilization review and medical decision making in general.

**Findings**

Fairly good overall agreement among observers on appropriateness of utilization of general hospital beds, but poor agreement on the groups of patients which one or more observers felt to be misutilizing. The mathematical model suggests that the degree of significant misutilization is actually less than the gross data indicates, and that more than one independent observer is necessary to estimate the amount of misutilization. A number of factors correlating with misutilization are delineated.

**Availability of Findings**

(a) Zimmer, James G.: "An Evaluation of Observer Variability in a Hospital Bed Utilization Study," *Medical Care*, July-August, 1967, Vol. V, No. 4. (b) Zimmer, J. G., et al.: Studies of observer variability and the methodology of hospital bed utilization review. (Presented at American Teachers of Preventive Medicine Annual Meeting, Miami, October 22, 1967; being prepared for publication). (c) Odoroff, C. and Zimmer, J. G.: Description of the mathematical model of observer variability (to be published).

16. STUDY OF USE OF MATERNITY BEDS BY SELECTED  
GYNECOLOGICAL PATIENTS

**Conducted by**

Selig H. Katz, M.D.; New York State Department of Health.

**Problem**

Effects of the admission of noninfected gynecologic patients to maternity services.

**Methods**

A study of one year's duration in the course of which each of six study hospitals was paired with a control hospital located in the same general area of the State. Admission of noninfected gynecologic patients to the maternity service of the study hospitals was permitted according to conditions of a study protocol, while in the control hospitals, traditional separation was maintained. Evaluation of

results was by a questionnaire administered to randomly selected maternity patients discharged from both types of hospitals regarding the presence or absence of themselves and their infants. The questionnaires of 1251 maternity patients discharged from study hospitals and those of 1470 maternity patients discharged from control hospitals were reviewed.

#### Findings

No untoward effects of the experiment were noted.

#### Availability of Findings

Not published.

### 17. COMMUNITY SERVICES RESEARCH AND DEVELOPMENT PROGRAM

(Progress Report)

#### Conducted by

Henry A. Sultz, DDS; Division of Community Health Services, Public Health Service, Department of Health, Education, and Welfare.

#### Problem

The exploration of health needs and wants of the public, and the design and implementation of appropriate community services.

#### Methods

The program makes it possible for a core unit of competent researchers from several health care and related fields to operate as an ongoing team in the exploration and assessment of specific areas where research is needed on a local level, in the development of sound research planning for the initiation of new projects in appropriate areas, in the effective interpretation of study findings, and in practical application of such findings based on a continuing familiarity with the community, its needs and services.

### 18. END RESULT MEASUREMENT OF QUALITY OF MEDICAL CARE

#### Conducted by

Sam Shapiro: Health Insurance Plan of Greater New York.

#### Problem

Approaches taken in the past to measure quality of medical care through end result studies and the potential for new studies.

#### Methods

Review of completed and current investigations including an assessment of their strengths and weaknesses.

#### Findings

More aggressive moves are needed to exploit present opportunities for end result studies. Before and after studies would be particularly useful in programs directed at special risk groups in the population and in demonstration projects where personnel and scope of services are being modified. Another class of observation studies deserving more complete exploration involves inter-comparisons in which effect is measured through an examination of differences in indices of health for populations in two or more medical care environments.

#### Availability of Findings

Shapiro, S: "End Result Measurements of Quality of Medical Care." *Milbank Memorial Fund Quarterly*, XLV: 7-30, April, 1967.

### 19. PATTERNS OF MEDICAL USE BY THE INDIGENT AGED UNDER TWO SYSTEMS OF MEDICAL CARE

#### Conducted by

Sam Shapiro; supported in part by the Health Research Council of New York. Research conducted by the Health Insurance Plan of Greater New York and Department of Health Services Administration and Department of Social Services of New York City.



**Problem**

The research was aimed at determining whether H.I.P.'s assumption of responsibilities for out-of-hospital care for about two-fifths of the Old Age Assistance and nursing home patients in New York resulted in changes in patterns of use in medical care and in mortality rates.

**Methods**

Comparisons were based on the medical and hospital care experience of 30 per cent samples of the OAA's in H.I.P. and of the OAA's not so enrolled; 50 per cent samples were used for nursing home patients. The experience among those who were on the rolls of the Department of Welfare on March 1, 1963, was followed for a year (March, 1963 through February, 1964). Welfare records on payments for medical services and goods and hospital care and H.I.P. records on care provided were the sources of information for measures of use. To determine comparability between the two samples, medical and hospital utilization during the year prior to the demonstration project were examined for these two groups. Mortality was determined from Welfare records.

**Findings**

Changes in pattern of physician utilization were experienced by ambulatory OAA's although overall physician and hospital utilization rates did not appear to be influenced by enrollment in H.I.P. The proportion of OAA's who received no physician services during the year went down somewhat in H.I.P. but remained unchanged in the non-H.I.P. group. In H.I.P. there was a shift from high dependence on home visits to out-patient care in the medical group center. Patients who tended to be low utilizers were likely to get more service when they were enrolled in H.I.P. than they did otherwise. Nursing home patients showed no change in physician or hospital utilization rates. During the study year, the death rates among the indigent aged in H.I.P. were about the same. In the next year and a half, mortality among the ambulatory H.I.P.-OAA's was lower than among the other OAA's.

**Availability of Findings**

Shapiro, S., Williams, J. J., Yerby, A. S., Densen, P. M. and Rosner, H.: "Patterns of Medical Use by the Indigent Aged Under Two Systems of Medical Care." *American Journal of Public Health*, 57: 784-790, May, 1967.

**20. COST AND CARE OF CHILDREN WITH CYSTIC FIBROSIS OF PANCREAS****Conducted by**

W. D. Bauman, M.D.; N.Y.S. Dept. of Health & Columbia Presbyterian Medical Center, N.Y.C.

**Problem**

Demography, medications, laboratory procedures, appliances and other aspects in the care of children with cystic fibrosis of the pancreas. Special emphasis on cost of the care of such children.

**Methods**

Automation of records of all C.F. patients in the out-patient department and of all hospitalized patients with C.F.P. between 1962 and 1965. Analysis of data by E.D.P. techniques.

**Findings**

460 patient-years of observation; from 1962-5 disclosed annual costs in O.P.D. of \$18 for visits, \$22 for laboratory tests and \$568 for drugs. Emergency care was required by 11% of the patients. Prevalence of diabetes, cirrhosis and cardiac disease was high. In-patient costs per patient per year were \$1,664.

**Availability of Findings**

Limited number of unedited copies of report available from:  
William A. Bauman, M.D., 622 West 168th St., N. Y., N. Y. 10032.

**21. PSYCHIATRIC TREATMENT AND PATTERNS OF MEDICAL CARE****Conducted by**

Raymond Fink, Ph.D.; sponsored by the National Institute of Mental Health.

Conducted by the Division of Research and Statistics, Health Insurance Plan of Greater New York.

#### Problem

To examine the impact of the introduction of a psychiatric therapy service on patterns of medical care provided for emotional disorders. On changes in patterns of care provided for patients with emotional disorders; changes in the nature of those emotional conditions referred to the psychiatrist and those retained for family physician care. From the point of view of the patient, the study examines the impact of changes in patterns of medical care and other aid sought and received by those with emotional disorders; and social and psychological characteristics of patients as these relate to patterns of medical care for emotional disorders and changes in these patterns resulting from the introduction of psychiatric therapy.

#### Methods

The study population includes members of the Jamaica Medical Group 15 years of age and older who saw a family physician during a three-month study period. Two random samples were selected, one of those for whom the family physician reported an emotional condition, the other of all other patients. Interviews are being conducted with family doctors and patients at two points in time, the first immediately prior to the offering of psychiatric care and the second two years hence.

#### Findings

One-fourth of those diagnosed as having an emotional problem were referred for a psychiatric consultation during the study's first phase. Referrals were most likely to go to patients whose emotional condition is described by the family doctor as "chronic" and to those for whom the emotional condition appeared to the doctor to be causing interference in regular life activities. Patients, for whom the family doctor found prescribed drugs or doctor-patient discussions relatively ineffective in treating the emotional problem, were more likely than others to be referred to the psychiatrist. Many of the patient characteristics, found from interviews of family doctors to bear a strong relationship to whether or not a referral is made, coincided with those found from patient interviews. Differences were observed among population subgroups in their likelihood to reach psychiatric treatment. Among some groups higher psychiatric utilization was linked to a greater likelihood of receiving a psychiatric diagnosis; among other groups higher utilization was brought about through a greater tendency to follow through on the psychiatric referral. Still another pattern leading to a high rate of psychiatric utilization appears to be through relatively high medical utilization generally.

#### Availability of Findings

Fink, R.; Goldensohn, S. S.; Shapiro, S.; and Daily, E. F.: "Treatment of Patients Designated by Family Doctors as Having Emotional Problems," *American Journal of Public Health*, 57, 9:1550-1564, 1967. Fink, R.; Shapiro, S.; Goldensohn, S. S.; and Daily, E. F.: The "Filter-Down" Process to Psychotherapy in a Group Practice Medical Care Program, *American Journal of Public Health* (in press). Copies available upon request.

## 22. ECONOMIC FACTORS AFFECTING THE COSTS OF PRESCRIPTION DRUGS IN THE GREATER METROPOLITAN AREA OF NEW YORK

(Progress Report)

#### Conducted by

Anthony T. Buatti; Summer Research Stipend — St. John's University.

#### Problem

The cost of prescription, over the counter, and proprietary medications and the relationship with different income levels and communities within the metropolitan area.

#### Methods

Data collected from pharmacies — selection of sample by type of store, location, city vs. suburban, income level of population, etc. Publication is expected in fall of 1968.

23. DELINEATION OF METHODS FOR EVALUATING AND APPRAISING  
 MEDICAL CARE PROGRAMS THROUGH UTILIZATION REVIEW  
 AND MEDICAL AUDIT

(Progress Report)

Conducted by

A. Gerald Renthal, M.D.; American Public Health Association, Program Area Committee on Medical Care Administration.

Problem

Medical care appraisal methods.

Methods

Descriptive survey, in evaluative and operational terms, with indication of the potential usefulness and limitations of each appraisal method. Description of current methods for utilization review and medical audit will be included. The work is being prepared by an editor with the assistance of expert consultants. This is not a research project but is intended for use by professional health personnel in organized medical care programs, and is being developed with the advice and consultation of appropriate professional organizations.

Availability of Findings

To be published under the title "A Guide to Medical Care Administration, Vol. III."

24. PHYSICIANS AND MEDICARE: A STUDY OF ATTITUDE CHANGE

(Progress Report)

Conducted by

John Colombotos, Ph.D.; U. S. Public Health Service, Division of Community Health Services.

Problem

The role of law as an instrument of social change is a problem with a long history. Empirical before-after studies of the effects of law on opinion and behavior, however, are scarce. This study has two aims: (1) to examine the effects of the passage of Medicare on physicians' attitudes toward Medicare; and (2) to examine the conditions under which these attitudes change.

Methods

The study builds on one-hour interviews with a probability sample of 1,205 private practitioners in New York State conducted in 1964 and early 1965 — before Medicare was passed. The interviews included questions on Medicare (hospitalization insurance for the elderly through Social Security,) government participation in medical care, the organization of medical practice, political attitudes, and on other related issues. A two-thirds subsample of the 1,205 practitioners, stratified on initial position toward Medicare, geographic area, political ideology, and religious preference, were reinterviewed between May and June, 1966 — nearly one year after the passage of Medicare and just before it went into effect. The remaining third were reinterviewed between February and April, 1967 — roughly six months after the program was in effect. This design makes it possible to separate the effects on attitudes of the law itself from the effects of its implementation, that is, of short-term experience with the program.

Findings

The analysis of data is now in progress.

Availability of Findings

To be published in articles submitted to professional journals and in monograph form.

25. THE ERIE COUNTY SURVEY OF LONG-TERM CHILDHOOD ILLNESS

Conducted by

Harry A. Sultz, DDS; Community Services Research and Development Program, Department of Preventive Medicine, School of Medicine, State University of New York at Buffalo.

**Problem**

To determine the incidence and prevalence of about 40 long-term diseases of childhood in Erie County, during a fifteen year period; to determine the associated mortality; to determine the burden or "impact" of each disease on the child, family, and the community; and to determine the epidemiological relationships of disease to variables such as age, sex, race, and socioeconomic status.

**Methods**

Information was obtained through detailed examination of records of all hospitals in Erie County and of hospitals in adjacent counties serving residents of the county, from certain community agencies, from selected physicians, and from a review of birth and death certificates. A sample of the families of the living children in the study group was interviewed to gather data relative to the "impact" of the illness on the individual, the family and the community. Information obtained will be related to race and socioeconomic status and to other pertinent factors available for the county as a whole from the 1960 decennial census.

**Findings**

For about 40 long-term diseases of childhood, annual incidence — 1946-1961, prevalence — 1961, associated mortality, hospital utilization, and hospital, physician and drug costs, all findings related to demographic variables.

**Availability of Findings**

Reprints available re: methodology. Incidence and Prevalence to be published in the *American Journal of Public Health*. All findings to be published in monograph form by the University of Pittsburgh Press, 1969.

26. UTILIZATION OF PROFESSIONAL PERSONNEL IN THE NEW YORK  
CITY SCHOOL HEALTH SERVICE

**Conducted by**

Mrs. Lucille Rosenbluth; Medical & Health Research Association of New York City, Inc., under a Community Health Services Grant from the Department of Health, Education, & Welfare.

**Problem**

(1) To develop, test and use methodology for studying professional utilization patterns to find out exactly how scarce skills are being used; (2) To establish a school health team that would devote the highest possible percentage of professional time to professional work, so the Department of Health could conduct a maximum program of highest quality with the limited staff available.

**Methods**

The project is in two parts: Phase I, to find out how nurses and other personnel were actually being used, by the work-diary or activity log technique chosen as the basic method of carrying out the study in Phase I of the project. Doctors, nurses and public health assistants were asked to keep chronological records of what they did during selected work days in their school health rooms. The sample of schools studied included 335 public and parochial elementary and junior high schools. Phase II consisted of a changed team approach to school health, based on facts obtained from Phase I, and aimed at much more efficient application of nurses and other personnel to school health needs. This experiment was conducted in three health districts in New York City.

**Findings**

(1) Professional nurses spent about a third of their time on nonprofessional activities; (2) Public health assistants were only partially effective in relieving nurses of nonprofessional activities; (3) Public health nurses were carrying out essentially the same duties and responsibilities as the staff nurses, who are not so highly trained; (4) Study data revealed that 36% of all staff time, including doctors, nurses and public health assistants, was spent in direct services to children which covered: health appraisal and case finding, immunizations, first aid, guidance counseling, health education, and relationships with community agencies and special resources. 63% of all staff time was spent on supportive activities which included administration, clerical operations, maintenance and housekeeping and incidental work. 1% of activities reported could not be coded; (5) More school health personnel time is spent on clerical operations than on any other single classification of work.

## Availability of Findings

Report on Phase I, *A Study of Utilization Patterns: Methodology and Findings* are available. Phase II findings will be made available.

## 27. HEALTH INSURANCE ASSOCIATION OF AMERICA STUDIES

## Conducted by

J. F. Follman, Jr., and Donald D. Jones for the Health Insurance Association of America.

## Description

1. *A Profile of Group Health Insurance In Force in The United States* — a survey of major companies.
2. *Dental Insurance Today* — Monograph on factors in dental insurance including volumes by type of carrier.
3. *Prescription Drug Insurance* — Monograph on factor in dental insurance including volumes and experiences by type of carrier.
4. *Role of Insurance Companies in Financing Hospital Care* — Monograph relating concepts of insurance design and significance of insurance benefits to hospital administration.
5. *Health Insurance and Health Care Statistics By State* — Compendium of Statewide data on extent of private health insurance for persons under 65, hospital statistics, and professional manpower.
6. *Insurance Company Coverages for Extended Care Facilities* — Survey of 21 companies writing over 50% of commercial health insurance.
7. *Private Health Insurance, 1967* — Evaluation of nature, scope and adequacy of coverage in force, cost and quality of care and characteristics of the uninsured.
8. *Health Insurance and the Effectiveness of Health Care* — Monograph.

## Availability of Findings

Health Insurance Association of America, 750 Third Avenue, N. Y., N. Y. 10017.

## 28. MEDICAL CARE FOR THE ELDERLY BEFORE AND AFTER MEDICARE

## Conducted by

Columbia University School of Public Health & Administrative Medicine. Co-investigators: Miss Regina Loewenstein, Dr. Eugene G. McCarthy, Jr., Mr. Paul N. Borsky.

## Problem

Shifts in the patterns of utilization and cost as a result of the passage of Medicare.

## Description

Sample population study of 6,000 social security recipients over the age of sixty-five recording their health experiences for one year prior to the date of interview. Two independent samples were drawn: one was interviewed in April and May of 1966 and the second group in October, 1967. To be published in late 1970.

29. NEED FOR NURSING HOME BEDS IN CATTARAUGUS  
AND CHAUTAUQUA COUNTIES

## Conducted by

Health Planning Council of Western New York.

## Problem

Adequacy and appropriateness of placement in existing nursing home and hospital beds, as well as numbers in private living arrangements who could be better cared for in nursing homes.

## Methods

Team Review (M.D., Social Worker, and RN) of appropriateness of placement

in nursing homes and hospitals. Also review of reports from public health nursing agencies, welfare agencies, and private physicians re known persons needing nursing home care.

#### Findings

Most nursing home beds are appropriately used. Need for more beds is evident.

#### Availability of Findings

Available at this office.

### 30. DEVELOPMENT AND MAINTENANCE OF TWO POPULATION LABORATORIES FOR THE STUDY OF THE DISTRIBUTION OF MENTAL DISORDERS AND THE DETERMINANTS OF THESE DISTRIBUTIONS

#### Conducted by

E. M. Gruenberg; Psychiatric Epidemiology Research Unit, Columbia University, 722 West 168th Street, New York, New York 10032.

#### Description

This Unit has done studies on the decreasing annual incidence of chronic (as contrasted to acute social) breakdown syndrome associated with long-term psychoses and methods for preventing chronic social breakdown syndrome. It has done studies on hospitalization rates for mental disorders in Dutchess County, N. Y., and Washington Heights Health District in N.Y.C. Symptom prevalence studies have also been done.

#### Availability of Findings

(1) E. M. Gruenberg, Ed.: "Evaluating the Effectiveness of Community Mental Health Services," Milbank Memorial Fund; (2) E. M. Gruenberg: "On Measuring Mental Morbidity," Symposium on the Definition and Measurement of Mental Health, National Center for Health Statistics, Washington, D. C. (3) E. M. Gruenberg: "Can the Reorganization of Psychiatric Services Prevent Some Cases of Social Breakdown?" Paper presented at the University of Toronto Formal Opening of the Department of Psychiatry in the Clarke Institute of Psychiatry, Toronto, Canada; (4) E. M. Gruenberg: "Social Breakdown Syndrome — Some Origins," American Journal of Psychiatry, Vol. 123, No. 12.

### 31. NATIONAL TUBERCULOSIS ASSOCIATION COLLABORATIVE INTERDISCIPLINARY OUTPATIENT RESEARCH AND DEMONSTRATION PROJECT

(Progress Report)

#### Conducted by

Harlan L. Stricklett; Sponsor: National Tuberculosis Association (New York); Research groups: University of North Carolina, Johns Hopkins University, University of California.

#### Problem

To study the characteristics and behaviors of persons (1) being served by an outpatient tuberculosis system, (2) those providing the services, (3) the administrative interface, and (4) to measure these variables against the dependent variable of health outcome.

#### Description

Being conducted in ten Health Department outpatient tuberculosis clinics in Baltimore, Md. (5 clinics), St. Louis County, Mo. (1 clinic), and San Francisco, California (4 clinics) under contract with the research groups (above) or Health Department. Principal investigators are multidisciplinary behavioral scientists. A cooperatively developed standard research protocol is being implemented at the three study sites. Data collation, processing, and analysis is handled at one central point. The study population consists of all persons above 16 years of age labelled by the clinic system as an "active" case of tuberculosis on or after April 1, 1967, and clinic staffs. Research will utilize a concept of systems analysis and research models. Ten study clinics will be treated as a separate subsystem. Components of the systems will be measured using standard protocol and research instruments. Data will

include (1) social and psychological profiles of patients, (2) standard medical data (historical and on-going), (3) professional evaluations of the patient, (4) monthly summary of patient services rendered, and (5) assessment of staff rendering services and the administrative milieu. The data will receive multivariate analysis to study the dynamic interrelationships of patient, staff, and administration so as to identify those variables casually associated with the dependent variable; the health outcome in those being served.

### 32. CHARGES FOR COMPLEX SURGERY

#### Conducted by

Charlotte Muller, formerly Assistant Professor of Administrative Medicine at Columbia University, with Institute of Surgical Studies, Montefiore Hospital.

#### Problem

Modern surgery requires varied and specialized technological and personal services, not only when the patient is in the operating room, but also during pre- and post-operative periods. These services are costly to hospital and to payment sources. There are numerous problems in measuring costs, including: the value of standby services; joint costs in multipurpose large hospitals; variations in hospital accounting practices; etc. This study represents a pilot attempt to use patient bills to identify: (1) incidence of services in pre-operative period, operative day and post-operative period; (2) importance of laboratory, X-ray and other departments in total charges for care; (3) relation of these distributions to complexity of principal procedure.

#### Methods

331 patients constituted a 20% sample of all surgical patients at a large teaching hospital in the 4th quarter of 1965. Operating room records were used to draw the sample; patient charts were searched for diagnoses, length of stay, etc.; bills were used to classify charges. Complexity was measured by the Blue Shield relative value scale on the basis of which the sample was divided into quartiles. Analysis of variance was used to isolate the effect of complexity as such from the influence of length of stay on mean daily charges for ancillary services.

#### Findings

Complexity was associated with size of total bill, and also with mean daily charges for services other than room and board. Average total charge for 7 leading classes of service also varied with complexity. For patients with very simple surgery, a larger portion of their bill was created by operating room charges. Patients with more complex surgery required more services per day than others in the week following surgery. In general, patients ever requiring oxygen, blood or special nursing, and those with multiple surgery or a stay of 11 days or more, were in the highest-cost group. A number of extreme cases of high utilization of special services were found. Proportions of bills due to laboratory and other services, and arising in pre-operative and other days were identified.

#### Availability of Findings

Published under title of "Complexity of Surgery as a Factor in Patients' Hospital Bills" in Medical Care, March-April, 1967, Vol. V, No. 2. Reprints: Address — Professor Charlotte Muller, City University of New York, 33 West 42nd Street, Room 1124, New York, New York 10036.

### 33. HOSPITAL-BASED SPECIALISTS STUDY: PATHOLOGISTS' AND RADIOLOGISTS' ARRANGEMENTS WITH HOSPITALS, 1966 AND 1965

(Progress Report)

#### Conducted by

Frank Van Dyke; Columbia University School of Public Health and Administrative Medicine, (under contract with the Social Security Administration, U. S. Dept. of Health, Education, and Welfare).

#### Problem

To identify shifts in the methods whereby Medicare-participating hospitals in the United States paid their pathologists and radiologists between December 31, 1965, and December 31, 1966. Projections were made also through December 31, 1967.

**Methods**

Data gathered in two ways: (a) from a statistical sample of hospitals, through circulation of a questionnaire; (b) from a non-random selection of 18 hospitals, upon which intensive case histories were drawn up.

**Findings**

Available thorough Social Security Administration after June 1, 1968.

**Availability of Findings**

After June 1, 1968.

**34. PERSONAL HEALTH SERVICES: UTILIZATION AND CHARGES****Conducted by**

Regina Loewenstein; Columbia University School of Public Health and Administrative Medicine under grant from Public Health Service.

**Problem**

Compare two types of interview schedules with regard to volume and accuracy of reporting utilization and charges for personal health services. In one schedule, probe questions were about conditions and services. In the other schedule, probe questions were about facilities used.

**Methods**

Interviews were sought from two matched samples of 1,000 housing units each, using different schedules with each sample. Verification of reported services was done by record checks and correspondence with private doctors. Two samples of about 1,000 known users of different types of facilities were also interviewed by the two schedules to compare under-reporting. All persons interviewed lived in one area of New York City with a population of 270,000.

**Findings**

There were little differences between the two schedules in measures of reported utilization and charges by community samples, accuracy of reporting services, and under-reporting of use of specific facilities. However, for some demographic sub-groups of the population there were differences between the two schedules in volume and accuracy of reporting.

**Availability of Findings**

Report of findings to be prepared in 1968.

**35. A STUDY OF HOSPITAL COSTS IN NEW YORK STATE**

(Progress Report)

**Conducted by**

Martin Saren; New York State Department of Health and Teamsters Joint Council No. 16 and Management Hospitalization Trust Fund.

**Problem**

(1) Gather and analyze information for the State of New York concerning the costs of providing hospital services; (2) Examine the methods and formulas employed in the determination of payments made to hospitals by government agencies and by hospital insurance corporations, including methods for determining the elements of cost; (3) Analyze auditing methods currently utilized in verifying reports and information furnished by hospitals relative to costs of hospital services; (4) Determine reasons for cost variations and indicate, to the extent possible, potential for cost reductions; (5) Recommend such modifications of data gathering and information seeking methods relative to the determination of cost of providing hospital services as may be indicated by the study and evaluation project.

**Methods**

Examination of financial reports; departmental cost variation analyses by observation and work sampling; experimentation with new indices for cost measurement.

**Findings**

Study in early stages.



**Availability of Findings**

Methodology and study description is available in preliminary detail.

**36. EVALUATION OF CHRONIC DISEASE SCREENING PROGRAMS****Conducted by**

A. W. Voors, M.D., DPH.

**Problem**

Consider a certain disease which has a sequence of three stages: one in which the disease can be arrested, one in which the disease cannot be arrested, but where treatment can prolong life, and one where neither is the case. Given the average durations of these three stages and the prevalence of this disease specified by age and by census tract, the problem is how many person-days of life expectancy are salvaged by an average screening examination of persons in the various age and census tract groups.

**Methods**

A mathematical model was developed. This model was applied to the cytology screening program for cervical cancer in Rochester, New York. Program utilization by age and census tract was assessed by drawing a stratified random sample from all women screened in Rochester during the year 1965.

**Findings**

(1) The model could predict future cervical cancer incidence in Rochester from past program utilization. This finding was considered to support the assumptions underlying the model. (2) If the screening program were directed at women not screened during the preceding five-year period, the age group of 45-54 years and the occupants of the high-risk census tracts would derive the most benefit per examination in terms of life expectancy salvaged. (3) If the screening program were directed at the female population at large, the age group of 65 years and over and the 55-64 year-old women in the high-risk census tracts would benefit most. (4) The conclusions (2) and (3) assume that the 30-49 years' age group does not have a shorter duration of the various disease stages than the other age groups. There is some evidence that this assumption is incorrect. Were this the case, then conclusions (2) and (3) may have underestimated the needs of this age group.

**Availability of Findings**

This report is unpublished, but is held by the New York State Department of Health in Albany.

**37. INQUIRY INTO THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE GOVERNOR'S COMMITTEE ON HOSPITAL COSTS (1965)****Conducted by**

Ray E. Trussell, M.D., MPH; Columbia University School of Public Health and Administrative Medicine, under contract with the Commissioner of Health of the State of New York.

**Problem**

The extent to which the recommendations of the Governor's Committee on Hospital Costs (Folsom Committee), 1965, have been implemented in general care hospitals, the State and Regional Hospital Review and Planning Councils, certain State departments, and other agencies concerned with hospitals (prepayment plans, insurance companies, and hospital associations) during the period 1965-1967.

**Methods**

A questionnaire keyed to the recommendations of the Governor's Committee report was sent out in January, 1967. Analyses were made to separate questions by: (1) 265 individual hospitals (85.2%) of the total (2) the 7 Regional Hospital Review and Planning Councils; (3) the State Hospital Review and Planning Council; (4) the State Departments of Health, Insurance and Social Welfare; (5) 18 other agencies and organizations.

**Findings**

A number of the recommendations have already been implemented. The most

important was the enactment in 1965 of Article 28 of the State Public Health Law, which gives great authority to the State Health Department and involves the State and Regional Hospital Review and Planning Councils in determining whether a new hospital or an extension to an existing hospital may be built or not. An impressive number of hospitals have taken steps as outlined in the Governor's Committee report to reduce costs or to keep them from escalating as fast as they had done in the past.

#### Availability of Findings

Copies of "Status of Implementation of the Recommendations of the Governor's Committee on Hospital Costs — Two Years of Experience, 1965-1967" have been sent to all respondents: the U. S. Public Health Service; professors of medical care administration; all medical school libraries and selected major reference libraries; selected national and voluntary organizations.

### 38. A STUDY OF THE EFFECTS OF MEDICAID ON HEALTH RESOURCE UTILIZATION AND OTHER HEALTH PRACTICES OF LOW-INCOME PERSONS

(Progress Report)

#### Conducted by

David Wallace, Ph.D.; Office of Research and Demonstrations, Social and Rehabilitation Service, U. S. Department of HEW. Research groups: Research Unit, Columbia School of Public Health and Administrative Medicine.

#### Problem

To study indicators of health, knowledge of local Title XIX program benefits (Medicaid), patterns of utilization, and expenses for health services of low-income families eligible and ineligible for medical services under Title XIX of the Social Security Act.

#### Methods

A national area probability sample of low-income families will be drawn to represent families eligible for Medicaid, ineligible in the same states, and similar low-income families in states without Medicaid benefits. Interviews will be conducted based on a questionnaire. The first measure will be taken in the spring of 1968 when Medicaid is in a relatively early state of development, and the second, three years later, in the spring of 1971, as the program matures.

#### Findings

Findings, based on data from the first phase, will be available in 1970.

### 39. RESIDENCY TRAINING IN COMMUNITY PSYCHIATRY

(Progress Report)

#### Conducted by

Dr. Richard Brotman, Director, Division of Community Mental Health, Department of Psychiatry, New York Medical College, 5 East 102 St., N.Y.C.

#### Problem

A training program to prepare psychiatric residents in principles and skills of community mental health in order to put learning into practice via teaching, research, and service in the problem area of alcoholism and drug abuse.

#### Description

Development of a special interdisciplinary training program in community mental health. Training activities involve agency interaction and case studies in substance abuse and careful design of intervention into community and group aspects of pathology as well as the therapeutic manipulation of individual elements.

### 40. TRAINING IN COMMUNITY MENTAL HEALTH

(Progress Report)

#### Conducted by

Dr. Richard Brotman, Director, Division of Community Mental Health, Department of Psychiatry, New York Medical College, 5 East 102 St., N.Y.C.

## Description

A pilot project to train professionals from a variety of disciplines in principles and skills of community mental health as they apply to problems of public health, such as drug and alcohol abuse. A teaching environment of work in a treatment facility, of theoretical orientation and of self-awareness. All trainees are at some point involved in the inter-related activities of the Division — research, teaching, and direct service. The program for the last year included: a sociologist, a public health nurse, a clinical psychologist, and two social work students in placement.

41. NEW METHODS OF ESTABLISHING A CONTINUUM  
OF COMMUNITY CARE FOR PROBLEM DRINKERS

(Progress Report)

## Conducted by

Dr. Richard Brotman, Director, Division of Community Mental Health, New York Medical College, Department of Psychiatry, 5 East 102 St., N.Y.C.

## Problem

To demonstrate and evaluate new methods of treating problem drinkers and of creating non-discriminatory staff attitudes and agency policies toward these chronically afflicted persons.

## Methods

Patients are treated on an out-patient basis with rehabilitation efforts directed at improving their physical, social and mental functioning. Staff is engaged primarily in community education, case coordination with other agencies and evaluating the progress of patients and of agencies toward specific goals.

42. A DAY-NIGHT CENTER FOR ADDICTED PERSONS

(Progress Report)

## Conducted by

Prof. Richard Brotman, Director, Division of Community Mental Health, Department of Psychiatry, New York Medical College, 5 East 102 Street, N. Y., N. Y. 10029.

## Problem

To study how drug users interact with, adapt to, and are affected by the community. To provide treatment for the user, information to help others understand substance use and to assist in the development of preventive programs and legislation, and training in the skills necessary to attend to the related physical, mental, and social dysfunctions.

## Methods

Comprehensive training, service and research program of all substance users referred from Greater New York area. Research analysis will focus on four levels — individual, social interaction, social organization, and culture or subculture — using a comparative approach. A monitoring and evaluation system has been developed throughout the program.

43. INSURED DENTAL CARE

## Conducted by

Helen H. Avnet; Group Health Dental Insurance, Inc.

## Problem

To measure utilization of dental services under a comprehensive fee-for-service dental prepayment scheme.

## Methods

Analyzed characteristics of all persons at risk during study period using paid claim records and membership records.

## Availability of Findings

*Insured Dental Care* published 1967 and available on request from: Mrs. Helen H. Avnet, Group Health Insurance, Inc., 221 Park Ave., South, New York, New York 10003.

## 44. PHYSICIAN SERVICE PATTERNS AND ILLNESS RATES

## Conducted by

Helen H. Avnet; Group Health Insurance, Inc.

## Problem

To measure utilization of physicians' services under a comprehensive fee-for-service prepayment scheme.

## Methods

Exposure obtained from Plan records and supplementary survey. Utilization obtained by analysis of claims records.

## Availability of Findings

Book available on request from: Mrs. Helen H. Avnet, Group Health Insurance, Inc., 221 Park Avenue, South, New York, New York 10003.

## 45. MEDICAL CARE OF INFANTS AND PRESCHOOL CHILDREN

(Progress Report)

## Conducted by

Rowland L. Mindlin, M.D., MPH; Medical and Health Research Association of New York City, New York Department of Health.

## Problem

What are the health problems of urban infants and preschool children as perceived by their mothers? How are these problems met? What are attitudes of mothers toward physicians, institutions, and care?

## Methods

Mothers of newborn infants were randomly selected from monthly birth registrations, then interviewed each month for a year. Preschool children were identified by doorbell ringing after area probability sample, and mothers interviewed bi-monthly for a year. A control group of each type was interviewed only once. Interviewing is completed, but analysis has just begun.

## Availability of Findings

Rowland L. Mindlin, M.D., MPH, Albert Einstein College of Medicine, 1200 Morris Park Avenue, Bronx, New York 10461.

46. CHARACTERISTICS OF PHYSICIANS ENGAGED IN PRIVATE PRACTICE  
IN A NEIGHBORHOOD OF NEW YORK CITY

## Conducted by

Schweitzer, Morton D., Ph. D., and Gearing, Frances R., M.D.  
Div. of Epidemiology, Columbia Univ. School of Public Health & Admin. Medicine;  
Health Research Training Program, New York City Dept. of Health.

## Problem

To obtain information from physicians in private practice regarding their practices, experiences with chronic patients, and opinions about coronary artery disease.

## Methods

The Washington Heights Health District of New York City was selected as the study area. About 270,000 persons, with a high proportion of elderly persons, are located in the area. Information was gathered by interviewing the physicians practicing in the area.

## Findings

For a specific, delineated city neighborhood, the study analyses the following pertinent information from the physicians: (1) type and characteristics of medical practice including hospital admitting privileges and case load of some common chronic diseases; (2) experiences with the diagnosis and treatment of chronic coronary artery disease; (3) opinions and recommendations with respect to diet, exercise, smoking, and the use of anticoagulants; and (4) an estimation of the current use of, and need for, laboratory and other services.

## Availability of Findings

AJPH — April, 1966. For further information: Morton D. Schweitzer, Ph.D., Assoc. Prof. of Epidemiology, Columbia Univ. School of Public Health and Admin. Medicine, 600 West 168th St., New York, N. Y. 10032.

47. 1966 INVENTORY OF REGISTERED NURSES AND FACTS  
ABOUT NURSING (ANNUAL)

(Progress Report)

## Conducted by

Eleanor D. Marshall and Evelyn B. Moses, project directors. Study being conducted by the American Nurses' Assoc. under contract with the Public Health Service, Dept. of Health, Education, and Welfare.

## Problem

To determine the number and characteristics of the nation's registered nurse manpower.

## Method

Data are collected through the cooperation of state boards of nursing. A standard set of questions is included on licensing application forms. Where this is not possible, special mail surveys of the registered nurses in a state are conducted.

## Availability of Findings

A special report of the survey will be published later this year. Findings will also be included in the 1968 edition of *Facts About Nursing*.

48. STUDY AND EVALUATION TO IDENTIFY AND DETERMINE REASONS  
FOR VARIATIONS IN THE COST OF PROVIDING HOSPITAL SERVICES

(Progress Report)

## Conducted by

Charles G. Roswell; School of Public Health and Administrative Medicine, Columbia University under contract with the Commissioner of Health of the State of New York.

## Problem

A 3-year study, this phase involves a review of methods and formulas employed in determination of rates of payment made to hospitals by hospital insurance corporations (Blue Cross) including methods for determining elements of cost taken into consideration in making such determinations. In evaluating findings, consideration shall be given to provisions regarding establishment of hospital rates contained in Article 28 of the New York State Public Health Law and in Public Law 89-97, The Health Insurance for the Aged Act.

## Methods

Basic data compiled from written agreements between Blue Cross Plans and Member hospitals specifying the manner in which payment rates shall be determined.

## Findings

Study not completed.

## Availability of Findings

Final report to be submitted to the Commissioner of Health of the State of New York.

49. AN ANALYSIS OF THE COMPONENTS OF RISING HOSPITAL COSTS

## Conducted by

J. Douglas Colman, President, Associated Hospital Service of New York.

## Problem

An analysis of the components of rising hospital costs.

**Methods**

Statistical analyses of up to twenty years of cost data for New York City area hospitals, by type of hospital and type of costs and an examination of some of the human, economic, and community organization reasons for the changes.

**Findings**

- (1) Largest per cent increases occurred in general patient care services, while largest dollar increases incurred in "hotel" services.
- (2) The rate of increase in per diem salary expense has been substantially greater for professional patient care services than for all other elements of hospital service.
- (3) There is some variation between hospitals that can only be explained in terms of efficiency.

**Availability of Findings**

Presented at National Conference on Medical Costs, June 27, 1967, Wash., D. C.

50.

**UTILIZATION REVIEW PROCESS**

(Progress Report)

**Conducted by**

Mark Freedman, M.D., Vice President, Associated Hospital Service of N. Y.

**Problem**

Supplying useful data to hospital utilization review committees.

**Methods**

Details of utilization for 20 selected common procedures and diagnoses by hospital, type of hospital, and all hospitals, including analysis by patient age and sex, pre-operative and post-operative stay, day of admission, surgery, and discharge.

**Findings**

A study of 1,460 cholecystectomy cases has been prepared and distributed.

**Availability of Findings**

Write: Associated Hospital Service of New York, 80 Lexington Avenue, New York, New York 10016.

51.

**ANALYSIS OF A NURSING AUDIT****Conducted by**

Maria C. Phaneuf; Associated Hospital Service of New York.

**Problem**

(1) Can nurses appraise the quality of patient care through examination of service records, and can such appraisals be developed into a specific audit? (2) Will nurses be receptive to such a method?

**Methods**

Audits were done on 500 patient care records of randomly or selected discharged patients. Seven categories of nursing functions and 50 derived components were used as standards, and rating scales revised.

**Findings**

Overall results showed that none of the patients whose records were audited received unsafe care, and 60% received good or excellent care. Ratings in each functional area pointed out specific areas of weakness. Following audit, many corrective actions were undertaken.

**Availability of Findings**

*Nursing Outlook*, Vol. 15, January, 1968, p. 57.

## 52. ECONOMIC BEHAVIOR OF THE PROPRIETARY HOSPITAL

(Progress Report)

## Conducted by

A. S. Yerby, M.D., Harvard School of Public Health.

## Problem

- (1) Factors which affect the growth of the profit hospital.
- (2) The effect of the profit objective in: a) determining the product mix; b) selecting methods of production of hospital services; c) stimulating efficiency.

## Description

This study is in its infancy. Because of the completeness and accessibility of their information, Blue Cross statistics for the hospitals in Southern New York (proprietary) will be used.

## NORTH CAROLINA

## 1. HOUSEHOLD ACTIVITY PATTERNS AND COMMUNITY HEALTH

(Progress Report)

## Conducted by

F. Stuart Chapin; U. S. Public Health Service and Center of Urban and Regional Studies, University of North Carolina, Chapel Hill.

## Problem

This study will give particular attention to the use by household heads and spouses of health and medical care facilities for non-emergency illnesses.

## Methods

Using a set of cluster points randomly distributed over the geographic extent of a metropolitan area, data are obtained in one-hour long interviews from respondents falling in cluster samples drawn at each such cluster point. Standard methods of statistical analysis will be used in tests of hypotheses. The approach followed includes recording the entire day's routine for a typical weekday and sampled weekend days for purposes of relating medical care episodes with the pattern of activities of the respondent. Of particular interest is a recording of visits to doctors, clinics or outpatient departments of hospitals for non-emergency needs, and respondent's views about the convenience of and access to services and facilities.

## Availability of Findings

Findings will be reported in the fall of 1969 or winter of 1970. For exploratory work on activity aspect of the study, see Chapin and Hightower, *Household Activity Systems — A Pilot Investigation*, May 1968, a monograph distributed through the Center for Urban and Regional Studies, University of North Carolina, Chapel Hill, N. C. 27514.

## 2. EXTENSION OF PREPAYMENT TO OUT-OF-HOSPITAL SERVICES

## Conducted by

Edwin L. Harmon, M.D.; National Forum on Hospital and Health Affairs, Duke University.

## Problem

This was a symposium on the Hospital Patient Outside the Hospital and undertook to examine the various available and developing resources for the care of patients in facilities other than hospitals.

## Methods

The symposium included presentations by 14 individuals on various aspects of continuing health care in various types of facilities. The various presentations were published by Duke University — the Graduate Program in Hospital Administration. A copy of the entire published report, presenting the experiences and views of various experts, would be available from Duke University.

**Findings**

That there are possibly a variety of alternatives to acute hospital care which can meet the needs of medically selected patients.

**Availability of Findings**

Write Duke University — See: *Hospitals*, Vol. 41, 3-1-67.

**OHIO****1. ROLE CONCEPTIONS OF PHARMACY AND COMMUNITY HEALTH****Conducted by**

David A. Knapp, Deanne E. Knapp, co-investigators, The Ohio State University, College of Pharmacy, supported by the Division of Community Health Services, U. S. Public Health Service Grant CH-00177.

**Problem**

This study was undertaken to gain information about the occupational role perceptions of the pharmacists, as held by the members of the general public, medical practitioners, and pharmacists themselves.

**Methods**

Two instruments were used in the study — statements describing possible characteristics of the generic pharmacist, was administered using the Sherif procedure, and semantic differential scale consisting of 19 pairs of bi-polar adjectives related to the meaning of the term pharmacist. Subjects included pharmacists, medical practitioners, and members of the general public. Appropriate statistical analysis were used.

**Findings**

Apparently the pharmacy groups underestimated the ideal pharmacist as perceived by the public. However these pharmacy groups as well as other subject groups did not appear to hold overly strong opinions about the pharmacist's role. This may be of advantage to pharmacy since persons who are not strongly committed to any viewpoint are most immunable to attitude change. Some degree of attitude change among all groups concerned would seem to be beneficial from the view point of better utilization of pharmacists' services.

**Availability of Findings**

A final report on the project will be available about June 15, 1968. Preliminary findings are recorded in a paper entitled "The Pharmacist as Perceived by Doctors, Customers, and Other Pharmacists" available upon request from the principal investigator.

**2. TASK ALLOCATION AND STRUCTURE OF HEALTH RESOURCES**

(Progress Report)

**Conducted by**

Kermit K. Schooler, Ph.D.; sponsor — Div. of Community Health Services, PHS. Research group: Research Center of the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University.

**Problem**

Research objectives are two-fold: (1) to compare various forms of organization of medical care with respect to allocation and performance of medically relevant tasks; (2) to infer from the comparison which form of organization is the most conducive to effective utilization of members of the health care team. The general hypothesis is that effective functioning of an organization for patient care is related to the structure of the organization.

**Methods**

Project was conducted in the Greater Cleveland area on a sample of patients drawn from private practices, out-patient clinics and pre-paid group. Personal interviews were conducted with patients and their related physicians and ancillaries. Analysis to be accomplished by application of cross-tabulating and statistical programs on high speed computer.



### 3. COMPUTER SYSTEMS AS RELATED TO TEACHING AND RESEARCH PROGRAMS OF THE COLLEGE OF MEDICINE

#### Conducted by

John P. Howell; National Institute of Health — General Research Support Grant and Ohio State University.

#### Problem

Research, design, and implement computer systems relating to medical school activities. Principal systems to be investigated to date include: (1) medical records search and retrieval; (2) computer assisted instruction for medical and allied medical students; (3) information storage and retrieval of clinical data; (4) conversion and reduction of analog measurements of physical cardiac parameters; (5) cost accounting and analysis by department; (6) menu planning and nutrition research; (7) computer concepts instruction for medical and allied medical students; (8) Cancer Registry.

#### Methods

Use of computer specialists working with physicians and other allied medical personnel to research, design, and implement the systems. A multi-disciplinary approach with various disciplines represented in addition to computer specialists depending on the system being designed.

#### Findings

It has been demonstrated that the computer can be a valuable tool in both the teaching and research programs of a medical school. The following programs from the above list are fully operational: (5) cost accounting and analysis by department; (7) computer concepts instruction for medical and allied medical students; (8) Cancer Registry. The other programs are still being designed and only partially operational.

#### Availability of Findings

There are no publications at the present time, but limited information could be made available upon request.

### 4. EVALUATION OF DISABILITY AND REHABILITATION POTENTIAL

#### Conducted by

Saad Z. Nagi, Ph.D.; the study was conducted by the Ohio State University, Tulane University, and the Kenny Rehabilitation Foundation. It was sponsored by the Social and Rehabilitation Services Administration.

#### Problem

A study in the legal, clinical, and self-definitions and assessment of disability and potential for rehabilitation. The study focused upon problems in decision making and the factors which influence decisions.

#### Methods

The sample was composed of applicants for disability benefits under social security (weighted sample of 2,454). Applicants received comprehensive evaluations by clinical teams representing the various clinical specialties in medicine, psychology, social work, vocational counseling, and occupational therapy. The study was designed to delineate the influence of 3 major factors in decision making — information, criteria, and human judgment. The study included a follow-up on those referred to rehabilitation agencies.

#### Findings

Many important findings were obtained which relate to the influence of information, criteria, and human judgment in the process of decision making. A number of findings also relate the social characteristics of applicants and the types of impairments to decisions regarding disability and rehabilitation potential. Factors associated with rehabilitation outcome were also identified.

#### Availability of Findings

A comprehensive report will appear in: *Disability and Rehabilitation: Legal, Clinical and Self Concepts and Measurement*, by Saad Z. Nagi, to be published by the Ohio State University Press, Columbus, Ohio, and to appear in November, 1968.

5. POPULATION TRENDS IN THE EIGHT-COUNTY  
OHIO-KENTUCKY-INDIANA REGIONAL PLANNING AUTHORITY AREA

Conducted by

Jerry N. Ransohoff; Greater Cincinnati Hospital Council.

Problem

Marriage Rates, Births (by order of birth), Birth Rates and extrapolated migration in order to project utilization of hospital and related health facilities and services.

Methods

Data derived from various sources, hospital birth records, bureaus of vital statistics, dwelling unit construction and demolition permits, residence electric meter installations and removals, etc.

Findings

Marriage rate increasing, birth number as well as rate declining from about 25.5/1,000 in 1957 to about 17.9/1,000 population in 1967. Number of first-born children about constant. Second births declining slowly since 1957. Third, fourth, and up births declining sharply. Growth in suburban areas still largest but not at previously rapid rate. Core city apparently stable. Little change in five years.

Availability of Findings

Available in periodic summaries and annual reports. Special reports prepared for certain agencies upon request.

6. CONTINUED CARE BY NURSES AND DOCTORS: AN EXPERIMENT

(Progress Report)

Conducted by

Amasa B. Ford, M.D.; Research Grants Branch, Division of Nursing, Bureau of Health Manpower, U. S. Public Health Service.

Problem

To study in a controlled, experimental manner the effects of care given by visiting nurses.

Methods

Unique research design permits separation of observer effects on patients from effects related to nurses' visits. The introduction of a research program into two service settings (hospital and visiting nurse agency) has influenced both service programs and required special strategies. Since nursing care is offered to all patients assigned to the randomly selected "treatment" group, the opportunity is presented to identify groups of patients who can best respond to such care. The criteria for the study are measures of the physical, psychological and social function of 300 patients discharged from a chronic disease hospital, assigned by a random system to treatment and control groups, and observed for 2 years.

Availability of Findings

Adams, M., Downs, T., and Deube, H. Nursing Referral Outcome for Post-Hospitalized Chronically Ill Patients. *Am. J. Pub. Health* 58 #1: 101-106, January 1968. Final report being prepared.

7. DETERMINATION OF THE VALUE AND NEED OF A CONTINUITY  
OF CARE PROGRAM, AND COST

Conducted by

Francis Smith, RN; Nursing Division of Lorain City Health Department.

Problem

The Visiting Nurse Association had given limited nursing care to patients in their home for several years. The area covered included the city of Lorain and the northern part of Lorain County. A maximum of 161 city resident cases received services in one year. With an estimated population of 73,243 in 1962, and approximately 10% over 65 years of age, a continuous "waiting list" at the hospital, and documented studies from other areas, it was felt there was a greater need than

was being met. Would a nurse-coordinator program encourage home care? What would such a program cost?

Methods

The proposed program was approved by the Medical Staff of the hospital. The nursing supervisor and the Health Commissioner discussed the program and received approval of the Hospital Superintendent and Director of Nursing Services. Two nurses were assigned to part-time duties as nurse-coordinator at the local hospital. Nurse coordinators explained program first at head nurse meetings, then at staff nurse meetings. When indicated, the Public Health Nurse visited the home to determine feasibility and/or help the family in preparing for the patient's return. When the home was determined not suitable, the patient was transferred to a Nursing Home.

Findings

The Project ended September, 1966, and the program was continued with local funds. The fourth full year of operation, 1966, 220 individuals received 2,821 nursing visits. In 1964, a Cost Study was made, using procedures developed by Marion Ferguson, R.N., Ph.D., in *How to Determine Nursing Expenditures in Small Agencies*. Findings include:

	*Average Time	Average Cost
Nurse Coordinator visit to Hospital	198.20 min.	\$12.94
Home evaluation visit	67.50 min.	4.21
Home Nursing visit (Guidance)	79.07 min.	4.98
Home Nursing visit (Therapeutic)	109.08 min.	6.87
Office Nursing visit	36.20 min.	2.24
Phone visit	17.61 min.	1.23

\*Time includes travel time to place of visit.

Availability of Findings

See above.

8. USE OF ECF'S IN THE GREATER CINCINNATI AREA

Conducted by

Jerry N. Ransohoff; Greater Cincinnati Hospital Council.

Problem

The Greater Cincinnati Health Service Area has approximately 2.1 ECF (SSA Certified) per 1000 population. Highest concentration is in Metropolitan Cincinnati. What is the effect of this high ratio on hospital stays of Medicare patients? Are there inter-regional differences? Does the utilization pattern differ from national patterns?

Methods

Information is gathered on a monthly basis on a patient-by-patient "change" system. This involved changes in status, diagnosis, care given, therapy and medical treatments. Monthly reports are generated from the input and are related to hospitalization and other factors.

Findings

Average length of stay of Medicare patients in the Cincinnati area declined from 15.9 to 15.4 days in the first six months of 1967, compared to the same period of 1966. It rose slightly in those areas of the region with few ECF beds and declined more than average in those with a high number of ECF beds. IMPORTANT: The average L/S for patients transferred to ECF's was 27 days in a hospital before transfer. We are trying to find out why. From the same data, we are setting up tables of age — diagnosis — length of stay relationships to determine departures from regional patterns and reasons for them. Same data are being used to try to evaluate need for new ECF's or expansion.

Availability of Findings

Available on request, for special purposes. Summaries available but no extended analyses for general consumption.

9. HOSPITAL UTILIZATION IN THE GREATER CINCINNATI  
HEALTH SERVICE AREA

Conducted by

Jerry N. Ransohoff; Greater Cincinnati Hospital Council.

Problem

How are the hospital inpatient facilities being used in an eight-county, three-state area?

Methods

This is a continuing study initiated in 1962. It extracts pertinent data on an individual discharge basis from a number of sources and processes them to determine community utilization patterns related to age, hospital service, method of payment, economic status, etc.

Availability of Findings

Reports are prepared for individual hospitals, and community summaries are made for general facility plan development. Summaries are available. Individual hospital reports are not, except with the permission of the individual hospital. Findings are evident in plan development rather than specific publications.

10. EMERGENCY ROOM UTILIZATION

Conducted by

Jerry N. Ransohoff; Greater Cincinnati Hospital Council.

Description

Comprehensive study of who uses hospital emergency rooms and why, where they come from and for what services. How they pay their bills and how they get to the emergency room. Study now covers approximately 175,000 ER visits per year. Also included are time of day of visits and age of patients.

Study shows that about 65% of emergency room visits are not "medical or surgical emergencies." (This does not mean that it isn't an "emergency" to the patient.) Depending upon the hospital, from 35 to 40 per cent of the ER visits are children. Bulk of patients come between 4 p.m. and 10 p.m. Initiation of a fee-for-service plan doesn't reduce visit load, may lead to increase, particularly for those patients who use private physicians but cannot reach them after 4 p.m.

Availability of Findings

Available on request. Special reports prepared for participating institutions for planning most effective staffing and utilization of ER services.

11. PREDICTING JUDGED QUALITY OF PATIENT CARE  
IN GENERAL HOSPITALS

Conducted by

Amasa B. Ford, M.D. et al.; Department of Medicine, Western Reserve University School of Medicine, Cleveland.

Problem

The quality of patient care in general hospitals.

Methods

(1) The "Directory of Approved Internships and Residencies" was the basic source of information. (2) Rating of selected hospitals by 14 physician experts.

Findings

(1) Rate judgments about the quality of patient-care in a hospital were generally consistent. (2) Confirmation of the original hypothesis that a method for predicting the judged quality of patient care at a general hospital can be developed.

Availability of Findings

A. B. Ford, R. E. Liske, R. S. Ort, and J. C. Denton. *The Doctor's Perspective*, Cleveland: Western Reserve University Press, 1967.

12. CLEVELAND HEALTH GOALS PROJECTS:  
DESCRIPTION AND ANALYSIS OF COMPREHENSIVE  
HEALTH PLANNING IN A METROPOLITAN AREA

Conducted by

Welfare Federation, through Health Goals Committee.

Problem

Determination of community health goals; study of existing health facilities and services and health status; comparison of existing profile against goals to determine priorities for development of health programs.

Methods

To determine goals, 30 health areas identified and a competent professional wrote position paper on a subject, reviewed by local panel and Goals Committee, compiled into Health Goals Model, with guides and recommendations for various systems in community such as the hospital system. Team of consultants served throughout. To determine existing situation, the method used included questionnaires, interviews, use of official health reports, population and other demographic studies. Also, analysis of process was undertaken by a process analyst.

Findings

Size and complexity of study prohibits recap of principal findings here. Table of contents (attached) shows areas covered. Basically the *Model* provides a guide for community health planning applicable to any community.

Availability of Findings

Available for purchase from Welfare Federation of Cleveland, 1001 Huron Road, Cleveland, Ohio.

13. DESIGN OF PREPAID DENTAL PLANS

Conducted by

V. P. Singh, Operations Research Department, Case Western Reserve University.

Problem

(1) Study of the effect of socio-economic variables on utilization; (2) Test for interaction between socio-economic factors and plan design factors; (3) Study of the effect of plan variables on utilization after eliminating the effect of socio-economic variables; (4) Study of the effect of plan variables on operating cost of plans; (5) Form the prediction equation for the total cost.

Methods

Various statistical techniques such as  $X^2$  test, Cochran Q test, Bartlett's test for homogeneity of variance, analysis of variance, Kendall's co-efficient of Concordance, Fitting of curves.

Findings

(1) Have identified those services which account for most utilization. (2) Established that it is essential to consider all the three socio-economic factors (sex, age, and income) as having contributory effects on the utilization level. (3) Observed specific interrelationships between socio-economic variables. (4) In order to get exact relationship between the variables, and the utilization level, it is necessary to analyze the plans separately for different Services. (5) Region and mode of operations do not effect significantly in about 50% of the Services, while the size and payment factor effect 80% of the Services. (6) Average utilization differs between the plans and there is a difference between large and small clinics. (7) Charts giving 95% Confidence Intervals for the Incidence of use for different plans are available. Cost vs. % of utilization charts are also available.

Availability of Findings

(1) *Data Collection and Analysis Procedures II*, Operations Research Group, Case Institute of Technology, Tech. Memo. No. 66, Sept. 1966.

(2) *Preliminary Data Analysis III*, Operations Research Department, Case Western Reserve University, Tech. Memo. No. 86, August, 1967.

(3) *Preliminary Data Analysis IV*, Operations Research Department, Case Western Reserve University, Tech. Memo., (to appear) June, 1968.

#### OKLAHOMA

### 1. PROJECT RESPONSIBILITY — A PROJECT IN THE PACKAGING AND DELIVERY OF HEALTH SERVICES IN RURAL COMMUNITIES TO BE BASED ON STUDIES OF RURAL HEALTH MANPOWER, HEALTH SERVICES AND HEALTH FACILITIES

(Progress Report)

#### Conducted by

Thomas Paint, M.D., Ph.D.; University of Oklahoma Medical Center.

#### Problem

The packaging, delivering and financing of health care to rural areas.

#### Methods

Two areas of divergent make-up, demographically and medically, who are without medical care will be compared and evaluated.

### 2. THE STUDY OF COSTS, UTILIZATION, AND FINANCING OF HEALTH AND MEDICAL CARE SERVICE IN OKLAHOMA

#### Conducted by

Ansel M. Sharp, Oklahoma State University, for the Oklahoma State Medical Association and Oklahoma Blue Cross-Blue Shield Association, Oklahoma Hospital Association, and American Medical Association. (See 1966 Proc., Vol. II., p. 426).

#### Problem

Extent and degree of voluntary health insurance coverage by age and family income class. Hospital admission rates and average days' stay. Personal health expenses by age and family income class. Public expenditures for health and medical care.

#### Methods

Population studied: Oklahoma's population and Oklahoma's hospital patient population. Types of data: data based on national household studies; data collected from local published and unpublished sources; and data generated from surveys (hospital survey, patient survey, and physician survey). Method of Analysis: empirical — a stratified statistical sample was designed to generate data.

#### Findings

No essential difference was found between the hospital expenses of insured patients and those of uninsured patients in the state. However, average hospital stay varies between those insured with Blue Cross and those insured with insurance companies (mean hospital stay is 5.9 per cent higher for Blue Cross). Hospital admission varies directly with income, but mean hospital stay varies inversely with income. A significant part of hospital and physician charges are paid by voluntary health insurance. Hospital Survey: no conclusive evidence of overutilization; insured patients bills average 12.8% higher than non-insured at all income levels, but no significant inferences can be made; Blue Cross paid 82% of average bill, while commercials averaged 56%.

#### Availability of Findings

*Oklahoma State Medical Association Journal*, June, 1967, Vol. 60, p. 375. For more information contact Dr. Sharp.

#### OREGON

### 1. ECONOMIC EFFICIENCY OF MEDICAL SERVICES MARKET

(Progress Report)

#### Conducted by

Carl M. Stevens; Research Grant from Division of Community Health Services, Public Health Service, DHEW.

**Problem**

An exploratory inquiry of broad scope — designed to develop general conceptual apparatus for application of economic analysis to the medical services industry and to identify more particular problems for subsequent more detailed investigation.

**PENNSYLVANIA****1. FOCUS ON EMOTIONALLY DISTURBED CHILDREN****Conducted by**

Mary B. Janavitz; Health and Welfare Association of Allegheny County.

**Problem**

The extent of the problem of emotional disturbance among children in Allegheny County and the number of such children being served by "treatment" agencies.

**Methods**

Estimates of the extent of the problem in other studies, one of which was conducted in Pennsylvania, were applied to Allegheny County. A mail survey was conducted of 35 "treatment" agencies, 19 child psychiatrists, 129 general psychiatrists, 99 psychologists, and two social workers in private practice to determine how many served disturbed children in a given month, the number of children served and the type of service rendered.

**Findings**

It was estimated that there were at least 27,000 emotionally disturbed children between the ages of 5 and 18 and that there were an additional 12,000 children below the age of 5 who might have emotional problems. During a given month, some 1,679 children, less than 5% of the estimated number, were reported as served by organizations and practitioners. An additional 377 children, not necessarily an unduplicated number, were known to be waiting for service. Private practitioners included 11 child psychiatrists, 24 general psychiatrists and 12 psychologists. Excluding one general psychiatrist who reported serving 300 children with convulsive disorders, the private practitioners served 270 children. Of the 1,109 children served by organizations, 43% were served by non-medical agencies rather than clinics or hospitals.

**Availability of Findings**

Report available for \$2 from: Health and Welfare Association of Allegheny County, 200 Ross Street, Room 606, Pittsburgh, Pa. 15219.

**2. HOSPITAL UTILIZATION REVIEW****Conducted by**

Hospital Utilization Project, 3530 Forbes Avenue, Pittsburgh, Pa. 15213  
Paul M. Lewis, M.D.

**Problem**

(a) Utilization of hospital facilities in Pennsylvania; (b) Extended care facility utilization in Western Pennsylvania; (c) Utilization review in rehabilitation centers; (d) Utilization review in psychiatric facilities; (e) Utilization review in an institution for the mentally retarded.

**Methods**

Collection of data by preparation of abstract of medical record of all discharged patients. EDP of abstracts and preparation of monthly and semiannual diagnosis and operation listings and indexes, physicians' index, discharge analyses, etc. Preparation of comparative length-of-stay reports for major diagnoses responsible for hospital admission.

**Findings**

Comparative length-of-stay rates among comparable hospitals, and for individual hospitals over periods of time. Selective medical audit information. Patient population data for short and long-range planning, hospital internal management, etc.

**Availability of Findings**

Available from the Hospital Utilization Project (H.U.P.).

## 3.

## THE HOMEBOUND PATIENT —

## DENTAL NEEDS AND METHODS FOR PROVIDING DENTAL CARE

## Conducted by

David Soricelli, DDS, MPH; Division of Dental Health, Philadelphia Department of Public Health in cooperation with the Philadelphia County Dental Society. (Supported by Grant #CH40-36, U.S. Public Health Service).

## Problem

(1) Identify and classify homebound population in Philadelphia and determine approximate size of this population; (2) Ascertain dental needs of a selected sample of this group; (3) Determine, after providing comprehensive dental care in the homes of these patients, the need for and the feasibility of a specific community homebound dental program.

## Methods

In cooperation with official and voluntary agencies having an interest in homebound patients, a registry of these patients was collected. A random sample of patients was examined and treated and an analysis made of time-cost factors as well as treatment rendered and results of this treatment.

## Findings

(1) Homebound individuals have cumulative dental needs aggravated by long periods with no professional dental care. (2) They put aside demand for dental care because of inability to pay for this care, greater problems brought about by their primary illness, and inaccessibility of community dental resources. (3) Home dental care is expensive dental care, since it utilizes professional manhours inefficiently. To complete this vicious circle, most homebound patients have their savings depleted, with little current income or support. (4) Most of the expense of a home dental care program in Philadelphia would have to be subsidized. (5) A responsible agency is necessary to coordinate and support the various activities needed to provide this service on a community-wide basis. (6) A wide range of dental services is possible to be provided on a home basis.

## Availability of Findings

(1) Progress reports. (final report available after April 1, 1968). (2) Paper published in *Pennsylvania Dental Journal*, April, 1967, pp. 114-117. (Dental Care for Homebound Patients in Philadelphia — Edward Bronstein, DDS, MPH). (3) Other publications in preparation.

## 4.

HEALTH NEEDS AND UTILIZATION OF HEALTH SERVICES  
AND FACILITIES: SULLIVAN COUNTY HEALTH SURVEY, 1964

## Conducted by

Virginia Colflesh; Bureau of Planning, Evaluation and Research, Pennsylvania Department of Health, Box 90, Harrisburg, Pennsylvania 17120.

## Problem

The objectives of the study were to obtain a broad view of the health needs and the utilization of health facilities in a sparsely populated rural area; to compile morbidity statistics; to estimate current health practice patterns; to reveal data from which clues could be obtained for the development of additional health programs or facilities in the community.

## Methods

Sullivan County, population 5,808, was selected as the survey area because it is rural and lies within the Appalachia Tract. It has only 2 physicians and 1 State public health nurse. No hospitals or clinics located within its boundaries. Medical facilities are available in neighboring counties but public transportation is limited to one bus a day. The types of data collected were: data regarding inactive medical and paramedical personnel in sample; use of physician; hospital and nurses in the past five years; incidence of accidents; and acute and chronic illnesses in families, immunization, nutrition, maternal and child health; income, mental and emotional health; dental and eye care statistics, and what the families considered to be their and the county's health needs. An interview schedule was used. Personal interviews were conducted with householders in every fourth household in Sullivan County and in every household in the borough of Dushore.



**Findings**

The findings indicated that the routine treatment of disease was acceptably provided in most instances. Gross neglect does not appear to exist but truly preventive medicine remains an ideal to strive for rather than an accomplished fact. In many households medical care is obtained only after the overt signs and symptoms of illness are already present. Preventive medicine and the early detection of illness before deteriorative processes have set in does not appear to be the general practice. In addition, certain health services that do exist in some parts of the State were not available to the people in Sullivan County in 1964.

**Availability of Findings**

A report on this study was printed by the Pennsylvania Department of Health. The original two hundred copies are depleted and due to the time factor (study conducted in 1964) have not been replenished. Xeroxed copies of the original are available on request.

5. **HOMEMAKER AND/OR HOME HEALTH AIDE SURVEY**  
(Progress Report)

**Conducted by**

Robert M. Crum; Research-Planning Division — Community Services of Pa., 300 North Second Street, Harrisburg, Pennsylvania.

**Problem**

Not problem oriented. We are trying to build a body of information about services that have grown like Topsy. Results will help agencies plan more effective services as well as provide guidelines for the development of new programs.

**Methods**

Questionnaires will be sent to approximately 200 agencies throughout Pa. Results will be machine tabulated and compiled into a report which will be studied by an Ad Hoc Committee which will draw conclusions and make recommendations.

**Availability of Findings**

Publication will be made available for general distribution.

6. **HEALTH MAINTENANCE STUDY OF A SELECTED GROUP**  
**OF OLDER PEOPLE**  
(Progress Report)

**Conducted by**

Silvia Taffe; Philadelphia Geriatric Center, 5301 Old York Road, Philadelphia, Pa. 19141.

**Problem**

To determine the efficacy of Preventative Medicine for the Elderly by establishing a periodic health appraisal and to determine the predictive value of these procedures for rate of survival.

**Methods**

The study group is 200 tenants of York House, an apartment house designed for elderly residents, 62 years of age or older. The group involved has received an intensive medical study each year for five years beginning in 1963. A control group of 200 community elderly of comparable age, socio-economic status and ethnic grouping has received a similar comprehensive study in 1963 and again in 1967. A complete history including medical, family and occupational background was taken on all study subjects. A complete physical examination was done including a rectal examination. Also included is a special cardio-pulmonary examination which includes chest photofluorogram and electrocardiogram. Laboratory tests included blood urea nitrogen, blood sugar, hematocrit, urine-protein and microscopic, blood cholesterol, and sedimentation rate. Special studies were done for ocular tension, vision and hearing. All data received on each subject is being coded in preparation for statistical analysis.

7. PHYSICIAN AND PATIENT ATTITUDES TOWARD A HOSPITAL  
HOME CARE PROGRAM

Conducted by

William G. Mather and Robert J. Hobaugh; Allentown, Pa., Hospital and U.S.P.H.S., grant #CH-40-38-A-63.

Problem

Acceptance of the hospital-based home care program.

Methods

Interviews with all patients and doctors in the program, and a sample of doctors not in the program.

Findings

The patients were over 90% accepting and approving of the program. The physician on the program, approving, with some complaint of extra paper work and some uneasiness at apparent loss of complete control; the physicians not in the program very suspicious of loss of control and fear of increasing home visits. The "accepting" doctors were more likely to have been consulted about the plans at an earlier stage than the non-accepting physicians. The patients' main complaint was that it was not covered by Blue Cross or Blue Shield.

Availability of Findings

See *Inquiry*, Vol. IV, Number 3, pp. 47-54, or write to Allentown Hospital, 17th and Chew Streets, for complete report.

8. DURATION OF MATERNAL POSTPARTUM HOSPITAL STAY —  
AN ECONOMIC OR MEDICAL PROBLEM?

Conducted by

Foundation for Medical Research Perinatal Study, Sydney H. Kane, M.D., Executive Director.

Problem

Duration of maternal postpartum hospital stay — an economic or medical problem?

Methods

Records were obtained from six hospitals each having over 2,000 deliveries per year. Cases involving fetal or neonatal deaths, premature infants, non-vaginal deliveries, mothers with complications, infants with morbidity recordings were excluded, as were cases from obstetricians involved in less than 25 deliveries per year. Data was segregated by doctor within two categories (less than 100, 100 or more) and the mean postpartum stay determined for each.

Findings

- (1) Range was 2 to 9 days, with 4 and 5 days reflecting the majority.
- (2) MD's involved with less than 100 deliveries per year had a 4-day mode, those involved with 100 or more had a 5-day mode.
- (3) The longer the anepartum stay, the shorter the postpartum stay.
- (4) Less variation occurred if total maternity stay were considered.
- (5) Propriety of 4 versus 5 day mode should be further examined.

Availability of Findings

Available from Foundation.

9. THE ATTITUDES AND ANTICIPATED BEHAVIOR OF  
DENTISTS TOWARD REIMBURSEMENT PLANS

Conducted by

Robert D. Eilers, Ph.D., The Leonard Davis Institute of Health Economics, University of Pennsylvania. (Under a grant from the U. S. Public Health Service.)

**Problem**

To study the reactions and attitudes of dentists to various arrangements for paying for dental services under private insurance and public programs and to anticipate the behavior of dentists, categorized by various characteristics in setting fees under such plans.

**Description**

The major study will survey, by means of a questionnaire, approximately 10% of the licensed dentists in the United States selected on a stratified sampling basis, with an over-sampling of the dental specialties and dentists in areas having the largest amount of dental expense coverage in force. The major study will be conducted in the late Spring, 1968. A pilot test was conducted in January and February of 1968. The scope and methodology for the research were reviewed by a National Consulting Committee of Dentists.

10. AN EVALUATION OF THE USE OF THE PHOTOFUOROGRAPHIC  
EXAMINATION

**Conducted by**

Philip C. Stein, M.D.; Department of Public Health and Preventive Medicine, School of Medicine, University of Pennsylvania.

**Problem**

An evaluation of change from general to specific utilization of the photofluorographic examination.

**Description**

Fractionation of utilization of Photofluorographic unit in a community health center, involving films on 2,332 persons in all. Nearly 6% of the 297 nursing home residents over age 50 were found to be inflicted with previously undiagnosed disease. Results not yet published.

11. A MODEL PRESCRIPTION RECORDING SYSTEM

**Conducted by**

Joseph E. McEvilla; University of Pittsburgh.

**Problem**

The development of a prescription drug cost and utilization knowledge availability and retrieval procedure within a relatively controlled environment. Such procedure of recording prescription information should develop into an optimized system that would be applicable with minimum modifications anywhere outside the controlled research environment.

**Methods**

Input data consist of patient, physician, and prescription identification, charge, drug, therapeutic class, quantity, strength and dosage form, age and sex of patient, prescriber location and medical specialty. Analysis is multivariate with coefficient of correlation and regression line relationship.

**Findings**

The procedure developed is practicable for acquiring data upon which to study cost and utilization of drugs by individuals and families. A definite relationship exists between utilization sex and age.

**Availability of Findings**

The methodology and types of data retrievals have been published in the *Journal of the American Pharmaceutical Association*. Reprints are available upon request to the project director. Additional findings will be available in the Fall of 1968.

12. HOSPITAL-BASED CERVICAL CANCER DETECTION PROGRAM

**Conducted by**

(1) Department of Obstetrics & Gynecology, Thomas M. Fitzgerald Mercy Hospital, Pa. (2) Hahnemann Medical College, Philadelphia, Pa.

**Problem**

The failure or success of hospital-based cervical cancer detection program.

**Methods**

1653 women studied at a voluntary and free Pelvic Cancer Detection Center from April 19, 1965, to May 27, 1965.

**Findings**

- (1) The women strongly wanted a hospital-based cervical cancer detection program;
- (2) people currently expect hospitals to fulfill a continuing larger role as a community health center.

**Availability of Findings**

*Obstetrics and Gynecology*, June 1966, 27: 791.

## 13. ANALYSIS OF PRIVATE DUTY NURSING

**Conducted by**

Blue Cross of Western Pennsylvania; Thomas Ross and Constance Kauffman.

**Problem**

The study was undertaken to determine and evaluate the demand, availability and use of private duty nursing under varying conditions.

**Methods**

Data was collected from the available sources at six general hospitals located in the city of Pittsburgh and the Nurses Professional Registry, District No. 6, of the Pennsylvania Nurses Association. Records and reports maintained by the Nursing Department in each hospital were the primary source of information. This data was supplemented and interpreted in personal interviews with key administrative and nursing personnel. Finally, much data was abstracted from the annual reports of the Pennsylvania Nurses Association.

**Findings**

- (1) Demand for private duty nursing care is greatly influenced by the existence of an Intensive Care Unit in the hospital. The data collected indicated a significant decrease in requests for private duty nursing care after the ICU is in operation.
- (2) Approximately 69% of the users of private duty nursing care occupied private room accommodations.
- (3) In Allegheny County, there has been an absolute decrease in the total number of requests being made for private duty nursing care over the past four years.
- (4) The use of Registered Nurses is approximately eight times greater than the use of the L.P.N.'s for private duty nursing care.
- (5) Two distinct patterns of usage were identified: (a) The patient who has private nursing care for either one or two full shifts shortly after admission or following surgery. (b) The patient who has either around the clock one shift of care for a long period of time.
- (6) The average annual charge to patients using private duty nursing care in 17 hospitals in Allegheny County is approximately \$99,000 per hospital.

**Availability of Findings**

Printed by Blue Cross of Western Pennsylvania, *Research Series*, Number 4, November, 1967.

## 14. HOSPITAL COST TRENDS

(Progress Report)

**Conducted by**

Blue Cross of Western Pennsylvania; T. B. Fitzpatrick and Kathleen Barker.

**Problem**

This study is concerned with the trend reporting and analysis of per diem total and departmental hospital costs (1952-1964). As previously reported to the hospitals in Western Pennsylvania, it is hoped that this study will lead to increased interest in the meaning of hospital cost experience and some new forms of reporting costs to hospitals.

**Methods**

The methodology of this study is listing and tabulations of per diem total and departmental hospital costs of the hospitals in Western Pennsylvania in the period from 1952 to 1964.

**Availability of Findings**

Final Report being prepared.

15. **HOSPITAL INCOME SURVEY**

(Progress Report)

**Conducted by**

Blue Cross of Western Pennsylvania ; C. Patrick Hardwick, Ph.D.

**Problem**

(a) To evaluate the performance of Blue Cross payments to hospitals in Western Pennsylvania in comparison to commercial carriers, Medicare, Medical Assistance, self-pay patients and other third party payers. (b) To ascertain with empirical data the reasons for behind hospital income problems by comparing third party payments as of per cent of total billings or charges.

**Description**

24 hospitals were selected according to a random sample stratified by four geographical areas and four bed-size groups. The data was obtained from inpatient ledger cards for all discharges in August and September of 1966. The detailed information gathered for each discharge was: age, length of stay, primary service, principal source of payment, group or non-group coverage, duplicate coverage, total charges, charges for operating/delivery room, time between billing date and final payment, amount of bill covered and paid by third party, patient payment unpaid balance, exclusion of benefits (type and dollar amount). Report to be generated will be reported for all hospitals in survey, for each individual hospital, for each bedsize group and for each geographical area. Publication plans indefinite.

16. **HOSPITAL UTILIZATION OF PITTSBURGH RESIDENTS BY  
SOCIO-ECONOMIC STATUS (CENSUS TRACT), 1968 PROGRESS REPORT****Conducted by**

Blue Cross of Western Pennsylvania ; Bernard Ferber.

**Problem**

Differences in hospital utilization by socio-economic status. Possible effect of Blue Cross coverage on the type and extent of hospital utilization.

**Description**

Estimates are available for the 1963 Pittsburgh population classified as Blue Cross and non-Blue Cross, for four census tract groupings. Census tracts have been grouped into four socio-economic categories based on census tract. A sample of approximately 10,000 Pittsburgh patients (of 80,000) have been selected from the 23 general hospitals in the area. Hospital admission rates will be calculated for the Blue Cross and non-Blue Cross population (by age, sex) for each socio-economic group. In addition, similar comparative analyses will involve the number and type of diagnostic and therapeutic services received. Note, however, that diagnostic categories have been collapsed from 39 to 30 to get more meaningful numbers of cases.

Not fully completed at this time; report being written.

17. **DETERMINANTS OF THE VOLUME OF SERVICE PROVIDED  
TO MATERNITY PATIENTS**

(Progress Report)

**Conducted by**

Blue Cross of Western Pennsylvania ; K. K. Ro, Ph.D.

**Problem**

To determine the factors that affect the service provided to maternity patients.

## Description

This study uses the data collected for the study, "Hospital Utilization by Census Tract." The volume of service provided for each of the 1,144 cases of delivery without complications has been analyzed with the use of the AID Program developed at the University of Michigan. The factors selected are accommodation, age, socio-economic level, marital status, employment status, living arrangements, and type of hospital coverage. Report being written.

18. METHODOLOGY IN EVALUATING THE QUALITY OF MEDICAL CARE —  
AN ANNOTATED SELECTED BIBLIOGRAPHY — 1962-1967

## Conducted by

Dept. of Biostatistics, Graduate School of Public Health, University of Pittsburgh;  
Blue Cross of Western Pennsylvania.

## Problem

The study involves a search for literature on objective methods of evaluating personal health services.

## Methods

In the bibliography those articles are included that contain:

- (1) Statements of standards and recommendations for good medical care;
- (2) Evaluations of physician and nurse performance;
- (3) Measurements of the affects of care as an evaluation of quality.

## Availability of Findings

Approximately 200 items will be included in bibliography which is presently being prepared in its final form.

## PUERTO RICO

1. CONTINUING MASTER SAMPLE SURVEY OF  
HEALTH AND WELFARE SERVICES

## Conducted by

Else Homs de Calderon; Department of Health of the Commonwealth of Puerto Rico.

## Problem

Problems of Community, health and welfare including chronic disease and disability incidence, related utilization of health services and facilities, health service expenditures and technical awareness of health measures and services.

## Methods

Repetitive interview of 3,000 households annually (750 quarterly) selected to represent entire Island population selected by multistage stratified area probability.

## Findings

The Master Sample Survey was set up around four years ago as a research instrument to deal with the problems outlined above, and to provide information on morbidity and related subjects. A number of problem areas have been given partial attention, but the main publications are outlined as follows:

- |                   |                      |
|-------------------|----------------------|
| a—Health and Work | e—Mental Retardation |
| b—Mental Health   | f—Medical Expenses   |
| c—Dengue          | g—Health Insurance   |
| d—Cancer          |                      |

## Availability of Findings

Available from the Department.

2. DEMONSTRATION PROGRAM FOR DENTAL CARE FOR THE AGED  
AND/OR CHRONICALLY ILL

Conducted by

Dr. Lowell E. McKelvey; conducted by — School of Dentistry, U. of Puerto Rico.  
Sponsored by: U. S. Public Health Service.

Problem

Dental needs of the chronically ill and aged population segment in Puerto Rico, the time and manpower requirement to satisfy these needs and the costs involved.

Methods

Study was carried out on approximately 1,100 patients believed to be representative of this population segment. Data was collected on machine records. Time was computed for each type of procedure required in actual practice. Costs were based on the incidence of the various dental diseases and defects per 100 patients and related to the manpower required to correct these defects per 100 population. Facilities requirements and materials were related to these findings. Monograph being published.

RHODE ISLAND

1. AREA HOSPITAL STUDY

(Progress Report)

Conducted by

Paul Carvisiglia; Rhode Island Health Facilities Planning Council, Inc.

Problem

The Council's program of action relates to two aspects of health facility planning: (1) the elimination of needless duplication of services and facilities; and (2) the development of a more comprehensive and coordinated pattern of such services in the community.

Methods

The Council conducts various studies of populations, their use of hospital and nursing home services, and the manner in which specific institutions relate to these populations. Most of the initial work of the Council has been concerned with review of already completed plans of facilities. As the Council progresses, its function changes from one of review of completed projects to involvement in the basic planning processes of the institutions with which it is concerned. One of the processes by which this is accomplished is the Council's direct membership or involvement with the long-range planning committee of the institution.

Findings

The principal findings of the Council in its first 17 months of operation are in the form of advisories pertaining to specific programs of hospital development. These advisories are forwarded to the state Hill-Burton authority (R. I. Dept. of Health) and R. I. Blue Cross and Physicians Service. They involve Council determinations of whether the proposed programs are or are not in the public interest.

Availability of Findings

Reports of these activities are available upon request.

2. CONSUMER PATTERNS OF THE AGED, 1950-60

Conducted by

Sidney Goldstein; sponsored by the National Institute of Child Health and Human Development, Department of Sociology and Anthropology, Brown Univ.

Problem

Data from the Bureau of Labor Statistics Consumer Expenditure Surveys of 1950 and 1960-61 are being analyzed to evaluate changes in the income, expenditure and savings patterns of the aged population between 1950 and 1960 and to assess the degree to which the consumer behavior of the aged differs from that of other age segments of the population and the reasons that account for these differences. Among the categories of expenditures being investigated are those for medical care.

**Methods**

The data were collected in nationwide surveys by the Bureau of Labor Statistics. The 1950 data refer to the urban U. S. population. The 1960-61 data report the entire U. S. population and are subdivided by urban and rural place of residence. The statistics are available for a large number of variables, including age, family size, sex of head of household, race, occupation, education, etc. The data are being subjected to multi-variate analysis in order to identify the factors accounting for the different pattern of consumption by the aged.

**Findings**

Aged units continue to have a significantly greater concentration in the low income levels than any other age group. Differentials in expenditures, by age, in 1960-61 were actually greater than those characterizing 1950.

**Availability of Findings**

Findings have been published in a series of articles appearing in sociological and gerontological journals. Reprints are available from the author. Completed study will be published as a monograph in 1969.

**TENNESSEE****1. COMPREHENSIVE INJURY CONTROL PROGRAM**

(Progress Report)

**Conducted by**

E. W. Fowinkle; Memphis and Shelby County Health Department.

**Problem**

(1) Identification of the problem associated with accidental injury and death; (2) Epidemiological investigation of injuries associated with children; (3) To conduct field research into the specific causes of injuries; (4) The development and initiation of continuing injury prevention programs in the secondary school system.

**Methods**

Morbidity data will be collected from five hospital emergency rooms totaling approximately 50,000 cases per year and analyzed by computer systems.

**Availability of Findings**

Annual progress reports will be made available to all interested organizations and agencies upon request.

**2. RETAINER PAYMENT FOR PHYSICIANS' SERVICES****Conducted by**

Allen B. Koplín, M.D., for United Mine Workers of America Welfare and Retirement Fund.

**Problem**

There are three well-known methods used to pay physicians — salary, fee-for-service, and capitation. The retainer is described as an intermediate method which is neither salary nor fee for service. It is likened to a fee for time and this report is a description of the method and its implications for simplification of administrative workload in a medical care program, as well as the advancement of physician planned confidence, the quality of care, and the development of group practice and new patterns of service.

**Methods**

The experience of the Welfare Fund Area Medical offices in Birmingham, Alabama, and Knoxville, Tennessee, covering four Southeastern states (Alabama, Kentucky, Tennessee and Virginia) is described and samples of some 500 retainer arrangements are used as a basis for the description.

**Findings**

Although there are disadvantages, it is suggested that, in general, retainers are



advantageous both for the patient, the physician and the Welfare and Retirement Fund.

#### Availability of Findings

*American Journal of Public Health*, Vol. 57, No. 8, August, 1967, p. 1363.

### TEXAS

#### 1. DETERMINANTS OF HEALTH SERVICES

##### Conducted by

Texas Hospital Association and Trinity University; Sam A. Edwards, Principal Investigator.

##### Problem

It is proposed to simulate health services in such a manner that component elements may be described in inter-related qualifiable terms and with sufficient flexibility to predict the variation of personnel and logistical requirements of each element as they interact. By reducing such a simulation to a computer base, health services requirements of an area may be calibrated in terms of personnel and logistical needs and with sufficient sensitivity to permit comparison of different health care programs and activities. Additionally, the developed model will be applicable to any geographic locality with a minimum of adjustment.

##### Methods

The Health Care System is being simulated on a computer base with selected on-going and evolving large population laboratories used to validate the model.

##### Findings

Model is in developmental stage. One aspect has been validated. Model is being expanded to include a comprehensive care system.

##### Availability of Findings

Preliminary findings are available.

#### 2. THE ADJUSTMENTS NECESSARY IN SMALL HOSPITALS' AND NURSING HOMES' ACCOUNTING SYSTEMS UNDER MEDICARE

(Progress Report)

##### Conducted by

Arthur T. Roberts, CPA, Ph.D.

##### Problem

The adjustments necessary in accounting for the small hospital and nursing homes under Medicare.

#### 3. A PILOT METHODOLOGICAL STUDY OF THE COST OF DEBILITATING CONDITIONS IN AREAS OF POOR AND OVERCROWDED HOUSING

##### Conducted by

John F. Wortham; Institute of Behavioral Research; Texas Christian University.

##### Problem

Investigate method involved in selecting methods of estimating the extra cost of debilitating conditions in urban areas.

##### Methods

Literature survey of cost estimating methods; personal interviews of respondents living in low income district of Fort Worth, Texas; analysis of records of public hospital and public health service.

##### Findings

The major conclusions in brief are: (1) This pilot methodological study did not reveal an increase in illness in an overcrowded census tract compared to a less crowded area. (2) The geographic mobility in the overcrowded tract was less than

the mobility in the less crowded areas. Age is probably a more important factor than housing. (3) For several diseases, overcrowding presents an environment in which contagious diseases thrive. (4) A clinic study, though expensive, provides the best approach for measuring the direct and indirect cost of ill health. (5) Data obtained from surveys of households, doctors, and druggists tend to be biased and must be used with caution. (6) Data secured from hospitals and public health services tend to be more reliable. Information for cost purposes must be constructed. (7) A major population shift has not occurred in the ghetto area since 1960. Such population shifts as have occurred have been in the expansion of the ghetto. This expansion and out migration of younger people has increased the average age in parts of the ghetto. The use of 1960 census data for sample design purposes is limited for census tracts in which there have been major demographic changes. Although there were some significant changes in the census tracts under study, these shifts were not so great as to destroy the usefulness of the 1960 census in designing the sample.

#### Availability of Findings

Write Institute of Behavioral Research and ask for A Pilot Methodological Study of the Cost of Debilitating Conditions in Urban Areas.

### UTAH BENEFIT RATING PROGRAM

(Progress Report)

#### Conducted by

C. Sylvia Willie; Blue Cross-Blue Shield of Utah.

#### Problem

The Program is designed to resolve a long standing need for better information on components of utilization and costs for both Blue Cross and Blue Shield. Identification of specific benefit riders at time of payment and amount paid under each will facilitate projections of costs based on information gathered from outside sources as individual components can be isolated and trends applied to these in particular.

#### Methods

To date, the system of coding and data isolation is being developed. Rating will involve using the population applicable to the benefit desired, either in total or as a sample depending on the number involved. Projection analysis involves using the appropriate sectors of the population and applying trends developed from external data.

#### Findings

Study in process.

#### Availability of Findings

Information may be obtained from Statistical Research Department, Blue Cross-Blue Shield of Utah.

## 2. INTERPERSONAL RELATIONSHIP IN REHABILITATION

#### Conducted by

William McPhee, Ph.D.; Vocational Rehabilitation Administration (now part of the Social and Rehabilitation Service). Group: Regional Rehabilitation Research Institute at the Univ. of Utah.

#### Problem

To conduct a core research program on interpersonal relationships in the rehabilitation process in a rural area which might ultimately improve rehabilitation counseling practices. (a) Related research; (b) Differences between clients who obtained their own jobs and those who were placed by counselors; (c) The interaction between client and counselor, client and family, client and physician, client and local environment. Similar studies using one member of the dyad as the counselor.

#### Methods

Methods of Analysis — Computers — giving frequency distributions, *t* scores, chi squares, coefficients of correlations and coefficients of contingencies.

Findings

(1) No significant differences between the group of male rehabilitants who obtained their own jobs and the group who had placement assistance in regards to marital status and age at application. (2) Significant differences between females; on the average those female rehabilitants who received placement assistance had higher self-concepts and a higher concept of other people in general.

Availability of Findings

Berger, E. M. The Relation Between Expressed Acceptance of Self and Acceptance of Others. *Journal of Abnormal Social Psychology*, 1952, pp. 47, 778-783.

3. ASSESSMENT OF COMMUNITY HEALTH SERVICES;  
SALT LAKE COUNTY, UTAH

Conducted by

Community Services Council, Salt Lake Area and Bureau of Economic and Business Research of the University of Utah.

Problem

(1) To gather facts regarding present health programs, facilities, and the adequacy of services; (2) to determine those areas which needed immediate and long-range attention; (3) to formulate an appropriate plan of action.

Findings

Studies may be obtained from the Community Services Council, 2025 Council Way, Salt Lake City, Utah.

VIRGINIA

1. EVALUATION AND IMPROVEMENT OF HOME CARE PROGRAM;  
RICHMOND, VIRGINIA

Conducted by

E. M. Holmes, et al.; Dept. of Preventive Medicine, Medical College of Virginia.

Problem

Evaluate existing structure of Home Care Program to improve program.

Methods

Review of documents; interviews with officials of health agencies; program evaluation.

Findings

Of 149 patients with chronic diseases supervised by Richmond Home Medical Care Program: (1) 95% were non-white — 65% were over 65, (2) 75% of patients had 3 or more diseases, (3) primary illness of more than half the patients was disease of cardiovascular system, (4) lack of visits of health personnel other than physicians.

Availability of Findings

- (1) Holmes, E. M. et al., The Richmond Home Medical Care Program. *Amer. Journal of Public Health*, 1953.
- (2) National Center for Health Statistics, Washington D. C.
- (3) Public Health Service — Publication #1062, Washington, D. C.

WASHINGTON

1. DESCRIPTIVE ANALYSIS OF WASHINGTON STATE CLASSIFICATION  
SYSTEM FOR NURSING HOMES AND NURSING HOME PATIENTS

Conducted by

Mary A. Rice; State Department of Public Assistance at the request of Health Economics Branch, Division of Medical Care Administration of the United States Public Health Service.

**Description**

The investigation traced the historical development of the nursing home program in the Department of Public Assistance. This included a description of the Division of Medical Care, the system of classification of nursing homes and of patients as well as the functions of the professional nurses employed by the Department.

**Availability of Findings**

Copies of the report were furnished by Health Economics Branch, Division of Medical Care Administration, United States Public Health Service. It is also available in the Washington State Library.

**2. STUDY OF COSTS AND PATIENT CHARACTERISTICS  
IN PROPRIETARY NURSING HOMES**

**Conducted by**

John Hackley; Hillhaven, Inc., Tacoma, Washington.

**Problem**

Distribution of 3,000 patients during a 12-month period in 10 extended care facilities in 7 States by diagnosis, age group and sex with an analysis of care needs, costs of care and charges.

**Methods**

Patient census studies, analysis of census distribution by diagnosis, age group and sex. Analysis of length of stay by age, sex and diagnosis. Analysis of costs of care and charges by length of stay, diagnosis, age group and sex.

**Findings**

Final report available late Spring, 1968.

**Availability of Findings**

Available upon request after late Spring, 1968, from Hillhaven, Inc.  
515 South M Street, Tacoma, Washington 98405.

**3. COST OF MENTAL HEALTH CARE UNDER CHANGING  
TREATMENT METHODS**

**Conducted by**

Kenneth M. McCaffree, Prof. of Economics, University of Washington;  
National Institute of Mental Health.

**Problem**

The choice between providing treatment for the mentally ill in general hospitals and community facilities or in State mental hospitals.

**Methods**

(1) The matching of population (most practical); (2) Cost per patient or per case — for relative economic efficiency.

**Findings**

(1) Average length of stay indicates an increase of 1.4 days in the general hospital and a reduction of 4 days/patient at the State Mental Hospital. (2) State Mental Hospital shows more patients over 65. (3) General hospital average per patient direct cost was less than State. (4) The overall relationship of average per patient costs is clouded, and is a weak ground upon which to make firm judgment about the relative economic efficiency of the two institutions.

**Availability of Findings**

(1) Public Health Service, *Conceptual Problems in Developing an Index of Health*, Publication #1000, Series 2, #17 (Washington: Gov't Printing Office, 1966).

(2) Kenneth M. McCaffree, "The Cost of Mental Health Care Under Changing Treatment Methods," *American Journal of Public Health*, Vol. 56, No. 7 (July, 1966) pp. 1013-1025.

4. PREPAYMENT OF DRUG COSTS UNDER A GROUP PRACTICE  
PREPAYMENT PLAN

Conducted by

Kenneth M. McCaffree, Ph.D., Dept. of Economics, University of Washington.

Problem

Prepayment of drug costs under a group practice prepayment plan.

Methods

A comparison of costs and utilization of prescription drugs under a group practice prepayment plan and national figures with an attempt to explain differences.

Findings

The unique and essential characteristics of the prepaid drug program studied are the bulk purchase and handling of drugs and administrative controls over drug utilization (peer monitoring, formularies, etc.)

Availability of Findings

See *American Journal of Public Health*, April, 1968.

WEST VIRGINIA

1. HEALTH FACILITY UTILIZATION BY PEOPLE LIVING  
IN WEST VIRGINIA HOLLOWES

Conducted by

Marilyn A. Jarvis Eckert, M.D.; Division of Preventive Medicine, Dept. of Medicine, West Virginia University, Morgantown, W. Va. — in cooperation with the Appalachian Center for Research and Development and the Institute for Human Resources, West Virginia University.

Problem

The health status and health facility utilization of peoples living in West Virginia Hollowes.

Methods

Three typical hollow communities were chosen in 3 south central counties of W. Va. for study by the Appalachian Center and three communities within one county were chosen by the Institute for Human Resources. The Division of Preventive Medicine studied these population groups with respect to medical, dental, and health facility utilization. Data were collected by household interviews by carefully trained medical students. A pre-tested questionnaire was used and results were tabulated by computer. Roger E. Flora, Ph.D., in statistics, aided in the analysis.

Findings

(1) Utilization varies by community, but is not explained by income levels; (2) Compared to national averages, utilization of physician services in the area of study was slightly lower, of dental services much lower, of hospitals fairly similar.

Availability of Findings

*The West Virginia Medical Journal*, January, 1967, and September, 1967.

*Archives of Environmental Health* — Vol. 13, October, 1966.

WISCONSIN

1. HEALTH DATA RESOURCE STUDY

(Progress Report)

Conducted by

Wisconsin Regional Medical Program.

Problem

What data on heart disease, cancer, and stroke are being collected for Wisconsin. How good is it. What are the major elements of the study.

**Methods**

Survey of all data collection agencies engaged in heart, cancer, and stroke projects.

**Availability of Findings**

Will be available June, 1968.

2. **HEALTH SERVICE DATA OF WISCONSIN, INC.**  
(Progress Report)

**Conducted by**

Sidney Shindell, M.D.; seventeen medical, hospital, industrial, insurance, and public interests in Wisconsin.

**Problem**

Length of stay for principal diagnoses and operative procedures.

**Methods**

Computer analysis of all hospital discharges.

**Findings**

Thus far only preliminary data available. Indications are that Wisconsin hospitals have shorter length of stay than Pennsylvania.

**Availability of Findings**

Data being accumulated. Publication of partial results expected within the year (1968).

3. **A SOCIO-PROFESSIONAL CHARACTERIZATION OF  
THE PRESCRIPTION-COMPOUNDING FUNCTION**

**Conducted by**

Glenn Sonnedecker; University of Wisconsin and American Foundation on Pharmaceutical Education.

**Problem**

In operative terms, what are the qualitative and quantitative dimensions of the compounding or manipulative function remaining to the community pharmacist in dispensing drugs? What are some of the implications of this function and loss of function in terms of occupational sociology, and what are the attitudes of pharmacists themselves toward this aspect of their function?

**Methods**

Literature review and social analysis of function; followed by field study of attitudes of sample of pharmacists in Dane County, Wisconsin, and frequency study of manipulative steps attributed to the filling of prescription orders received in actual practice.

**Availability of Findings**

Unpublished. Bound copy available for loan or Xeroxing at: Pharmacy Library, Pharmacy Building, University of Wisconsin, Madison, Wis. 53706. — a research report as one requirement for the M.Sc. degree (major: Social Studies of Pharmacy), cataloged under the above title with author-name: **Randolfo Rivera Gonzalez.**

4. **ANALYSIS OF THE NURSING HOME BENEFITS OF MEDICARE  
ON THE NURSING HOMES OF WISCONSIN**

(Progress Report)

**Conducted by**

J. E. Mosher; sponsored by United States Public Health Service.

**Problem**

An analysis of the effects of the nursing home benefits of Medicare in the nursing homes of Wisconsin.

**Methods**

Data were collected from a random sample of 25% of the free-standing private nursing homes in Wisconsin. Data included history and description of units, financial experience, range of services, staffing, and patient characteristics. Data has been collected twice, first in the summer and fall of 1966 and again in the summer and fall of 1967. The data will be analyzed to show the differences in operating patterns, financing, patient and facility characteristics and the like for nursing homes in 1966. Similar analysis will be made of the data collected in 1967, and the comparison will be made between the two sets of data to show the effects of the new financing mechanism both on those homes which qualify as Extended Care Facilities and those which do not.

**5. STUDY OF ORGANIZATION OF PEDIATRIC AMBULATORY SERVICES  
FOR PATIENT CARE AND TEACHING**

**Conducted by**

Children's Bureau, by Frederic M. Blodgett, M.D.

**Problem**

Procedures for integrating teaching and patient care, prior to Title XIX.

**Methods**

Personal visitation and inspection of selected clinics.

**Findings**

Municipal and county clinics generally overloaded with only limited time for adequate supervision and teaching.

**Availability of Findings**

In near future.

**APPENDIX: STUDY GROUPINGS**

**Preliminary Note**

The 265 studies abstracted for this report cover a wide range of problems, approaches and emphases. To make this report more useful, the editors have taken the liberty to categorize the studies, under the following headings:

Grouping	No. Studies
1. Ambulatory Care and Service Studies	20
2. Automation and Computer Applications	14
3. Cost and Expenditure Studies	
a. Overall Health Studies	14
b. Drugs	4
c. Hospitals	16
d. Physician and/or Professional Services	6
4. Dental Studies	11
5. Drug Studies	13
6. Group Practice Studies	12
7. Health Care for the Aged	24
8. Health Care for Lower Income Persons	16
9. Home Care	7
10. Illness Studies	
a. Overall	1
b. Cancer, Heart Disease, Kidney Disease	10
c. Maternal and Child Care	18
d. Mental Illness, Drug Addiction, Alcoholism	18
e. Other Illnesses	4
11. Medical Care	
a. Diagnosis	6
b. Evaluation	13
c. Treatment	2
d. Preventive	1
e. Rehabilitation	3
12. Medical-Social and Attitudinal Studies	
a. Patient Centered	27
b. Provider Centered	15

Grouping	No. Studies
13. Nursing	
a. Practice	7
b. Supply	2
c. Visiting Nurse Service and Home Nursing	3
14. Nursing Homes and Extended Care Facilities	10
15. Prepayment and Insurance Studies	53
16. Resources	
a. Coordination	5
b. Organization and/or Administration	17
c. Planning	13
d. Supply and Related Topics	22
17. Utilization, Measurement	
a. Health Services (Overall)	10
b. Drugs	3
c. Hospitals (Overall)	15
d. Hospitals (Particular Services)	9
e. Insured Benefits	11
f. Physician and/or Professional Services	5
18. Utilization Review (Analysis and/or Evaluation)	14

## STUDY GROUPINGS

Subject	State	Study No.	
1. Ambulatory Care and Service Studies:	California	4, 15, 21, 22	
	Colorado	2	
	Connecticut	1, 3	
	Illinois	13	
	Kansas	4	
	Massachusetts	16, 19	
	Missouri	3	
	New York	2, 13, 31	
	North Carolina	2	
	Ohio	10	
	Pennsylvania	5	
	Virginia	1	
	Wisconsin	5	
	2. Automation and Computer Applications:	Alabama	1
California		1, 2, 16	
Florida		1	
Idaho		1	
Massachusetts		11, 17	
Minnesota		8	
New York		5	
Ohio		3	
Pennsylvania		2, 10	
Wisconsin		2	
3. Cost and Expenditure Studies		a. Overall Health Services:	California
	Dist. of Columbia		4, 11
	Illinois		3, 4
	Maryland		3
	Michigan		5
	Nebraska		1
	New York		7, 28, 38
	Oklahoma		2
	Oregon		1
	Rhode Island		2
	b. Drugs:	Indiana	2, 3
		New York	22
		Washington	4
	c. Hospitals:	Georgia	1
		Illinois	1, 9, 12
		Kansas	7
		Maryland	3
		Massachusetts	1, 3, 7
		New York	33, 35, 37, 48, 49, 52
		Pennsylvania	14, 15



Subject	State	Study No.
<b>3. Cost and Expenditure Studies—(Cont'd.)</b>		
d. Physician and/or Professional Services:		
	California	29
	Illinois	6
	Missouri	4
	New York	32, 33
	Tennessee	2
<b>4. Dental Studies:</b>		
	Alabama	1
	Connecticut	6
	Georgia	2
	Illinois	2, 6
	Indiana	4
	New York	43
	Ohio	13
	Pennsylvania	3, 9
	Puerto Rico	2
<b>5. Drug and Pharmacy Studies:</b>		
	Indiana	2, 3
	Iowa	2
	Louisiana	1
	Minnesota	4, 7, 8
	New York	14, 22
	Ohio	1
	Pennsylvania	11
	Washington	4
	Wisconsin	3
<b>6. Group Practice Studies:</b>		
	California	20, 22, 27
	Connecticut	8
	Dist. of Columbia	3, 8
	Michigan	2, 3, 10
	New York	19, 21
	Washington	4
<b>7. Health Care for the Aged:</b>		
	California	3, 15, 21
	Dist. of Columbia	2, 10
	Florida	2, 3, 4, 5
	Iowa	1
	Maryland	2
	Massachusetts	2, 8
	Michigan	9
	New York	1, 19, 24, 28, 33
	Pennsylvania	6
	Puerto Rico	2
	Rhode Island	2
	Texas	2
	Wisconsin	4
<b>8. Health Care for Lower Income Persons:</b>		
	California	21
	Colorado	1
	Florida	2
	Illinois	7, 14, 15, 16
	Kentucky	1
	Massachusetts	21, 22
	New York	19, 38, 46
	Puerto Rico	1
	Texas	3
	West Virginia	1
<b>9. Home Care:</b>		
	Connecticut	3
	Illinois	13
	Massachusetts	19
	Missouri	3
	New York	13
	Pennsylvania	5
	Virginia	1

Subject	State	Study No.
10. Illness Studies		
a. Overall:	Dist. of Columbia	4
b. Cancer, Heart Disease, Kidney Disease:	California	14
	Maryland	2
	Minnesota	2
	New York	9, 10, 14, 36, 46
	Pennsylvania	12
	Wisconsin	1
c. Maternal and Child Care:	Alabama	1
	California	9
	Colorado	1, 2
	Dist. of Columbia	1
	Georgia	4
	Illinois	14, 16
	Kansas	1
	Kentucky	1
	New York	16, 20, 25, 45
	Pennsylvania	1, 8, 17
	Wisconsin	5
d. Mental Illness, Drug Addiction, Alcoholism:	California	13, 18, 20
	Dist. of Columbia	12
	Georgia	2
	Hawaii	1
	Kansas	12
	Maine	1
	Michigan	6
	New York	5, 21, 30, 39, 40, 41, 42
	Pennsylvania	1
	Washington	3
e. Other Illnesses:	Massachusetts	11
	New York	31
	Tennessee	1
	Texas	3
11. Medical Care		
a. Diagnosis:	California	2, 20
	Illinois	10
	New York	36
	Pennsylvania	10, 12
b. Evaluation:	Colorado	2
	Connecticut	5, 6
	Florida	2
	Illinois	18
	Minnesota	9
	Ohio	11
	New York	15, 18, 23, 51
	Pennsylvania	15, 18
c. Treatment:	Michigan	21
	Minnesota	2
d. Preventive:	Pennsylvania	6
e. Rehabilitation:	Massachusetts	8
	Ohio	4
	Utah	2

Subject	State	Study No.
12. Medical-Social and Attitudinal Studies		
a. Patient Centered:	California	10, 14
	Connecticut	7
	Illinois	14, 15
	Indiana	5
	Kentucky	1
	Massachusetts	5, 21, 22
	Michigan	8, 10
	Minnesota	1, 5, 6
	New Jersey	1
	New York	7, 8, 10, 12, 45, 50
	North Carolina	1
	Ohio	4
	Pennsylvania	3, 7
	Utah	2
b. Provider Centered:	California	6
	Connecticut	5, 6
	Illinois	5, 10
	Iowa	1
	Massachusetts	5
	New York	3, 24, 52
	Ohio	1
	Pennsylvania	7, 9
	Utah	2
	Wisconsin	3
13. Nursing		
a. Practice:	California	3
	Colorado	1
	Massachusetts	9
	Missouri	1
	New York	4, 51
	Pennsylvania	13
b. Supply:	California	24
	New York	47
c. Visiting Nurse Service and Home Nursing:	California	5
	Ohio	6, 7
14. Nursing Homes and Extended Care Facilities:	Kansas	13
	New York	12, 29
	Ohio	8
	Pennsylvania	5, 7
	Texas	2
	Washington	1, 2
	Wisconsin	4
15. Prepayment and/or Insurance Studies:	California	9, 13, 17, 19, 20, 25
	Connecticut	2, 8
	Dist. of Columbia	2, 3, 6, 8, 10, 12
	Florida	2, 3
	Hawaii	1
	Illinois	3
	Kansas	2, 3, 4, 5, 6, 7, 8, 9, 10
	Louisiana	1
	Massachusetts	13, 14, 15, 16, 17, 18, 19
	Michigan	2, 3, 5, 10
	Missouri	2
	New York	7, 13, 21, 27, 43, 44, 49, 50
	Ohio	13
	Oklahoma	2
	Pennsylvania	9, 15
	Utah	1

Subject	State	Study No.
16. Resources		
a. Coordination:	California	6
	Indiana	1
	Minnesota	3
	New York	8, 83
b. Organization and/or Administration:	California	7, 23, 25
	Connecticut	4
	Florida	1
	Illinois	9
	Iowa	2
	Michigan	1, 4
	Minnesota	4, 7
	New York	52
	Ohio	2, 6, 7
	Oklahoma	1
	Oregon	1
c. Planning:	California	11, 16, 26
	Connecticut	5, 6
	Minnesota	1
	New Jersey	1
	New York	17
	Ohio	1, 5, 12
	Rhode Island	1
	Utah	3
d. Supply and Related Topics:	California	22, 24, 27, 28, 29
	Dist. of Columbia	7, 9
	Illinois	8, 17
	Kansas	11
	Massachusetts	6, 7, 15, 20
	New Jersey	2
	New York	1, 9, 17, 29, 47, 52
	Texas	1
17. Utilization, Measurement		
a. Health Services (Overall):	Illinois	4, 7, 16
	New York	28, 34, 38
	North Carolina	1
	Pennsylvania	4
	Puerto Rico	1
	West Virginia	1
b. Drugs:	Indiana	2
	New York	14
	Pennsylvania	11
c. Hospitals (Overall):	California	1, 8, 26
	Dist. of Columbia	5
	Idaho	1
	Illinois	11
	Kansas	8
	Massachusetts	6, 10, 17, 18
	Michigan	7
	Minnesota	1
	Ohio	9
	Pennsylvania	2
	Wisconsin	2
d. Hospital (Particular Services):	California	18
	Florida	6
	Maine	1
	Massachusetts	12
	New York	16
	Ohio	10
	Pennsylvania	8, 17
	Wisconsin	1

Subject	State	Study No.
17. Utilization, Measurement—(Cont'd)		
e. Insured Benefits:	California	13, 20
	Hawaii	1
	Kansas	2, 3, 6, 8
	Missouri	2
	New York	6, 7, 11
f. Physician and/or Professional Services:	California	22
	Illinois	17
	Massachusetts	16
	New York	26, 44
18. Utilization Review (Analysis and/or Evaluation):	California	26
	Florida	2
	Kansas	2
	Maryland	1
	Minnesota	1
	Missouri	2
	New York	7, 15, 18, 23, 50
	Pennsylvania	16
	Texas	1
	West Virginia	1

Variable Annuities (E6) Subcom. Report  
(Mtg. 23)

The (E6) Subcommittee met at 2:30 P.M. June 17, in Ballroom A, Portland Hilton Hotel.

The Chairman reported interim meetings of the Subcommittee were held April 30, 1968 in Baltimore, Maryland, and June 5, 1968 in Chicago, Illinois. The Industry Advisory Committee participated in both of these meetings.

Members of the Subcommittee also visited the offices of the Securities and Exchange Commission and the National Association of Securities Dealers.

The Chairman called on Larry D. Gilbertson, Senior Vice President and General Counsel, Participating Annuity Life Insurance Company, to give the report of the Industry Advisory Committee. Mr. Gilbertson introduced the members of the Industry Advisory Committee who were present and then indicated certain changes which have been made in the copy of the Model Variable Contract Regulations which is attached. Several Commissioners and their representatives commented on and raised questions about certain parts of the proposed Regulation. Mr. Gilbertson noted that the Regulations are meant to be uniform minimum regulations and that individual states may adopt more stringent requirements if they believe they are necessary. Mr. Gilbertson's statement to the Subcommittee is attached to this report.

The Chairman noted that the exact form of the Commissioner's Report of Examination which is attached and follows the Model Variable Contract Regulation is subject to revision after consultation with the Securities and Exchange Commission.

The proposed application identified as Uniform Form, AP, which may be used to meet the requirements of Article IX, Paragraph 2. The Informational Memorandum attached is a so-called "primer" regarding licensing of variable annuity contract salesmen.

Honorable Joe B. Hunt of Oklahoma reported that he has adopted rules applicable to variable annuities which will become effective July 8, 1968. Copies will be sent to all licensed insurance companies and everyone who needs a copy should contact Commissioner Hunt.

The Chairman reported that two new examinations for the Securities portion of the Variable Annuities agents' examination have been approved by the Securities and Exchange Commission. These examinations will

be denoted "Form A (6-68)" and "Form B (6-68)." The Chairman also read a memorandum which explained how states may obtain Securities Exchange Commission approval for their use of examinations to qualify Variable Annuity agents. A copy of this memorandum is attached and made a part of this report.

The Chairman reported that as of April 9, 1968, thirty-one States (ref: 1968 Proc. Vol. I p. 222; also see note at end of this report) had filed the Variable Annuities examination with the Securities and Exchange Commission.

In Executive Session W. Harold Bittel, New Jersey, moved that the Subcommittee adopt the Model Variable Contract Regulation as presented by the Industry Advisory Committee, with the changes suggested by Mr. Gilbertson during the regular meeting. Commissioner Farnam of Massachusetts seconded the motion. The Regulations were to be adopted with the stipulation that there are to be minimum regulations and that individual States have the option to strengthen them as they see fit. General discussion followed and Commissioner James H. Hunt, Vermont, moved that Line 7, in Paragraph 1, Article VI, the word "may" should be changed to "will". Mr. Bittel seconded this motion and it was subsequently passed unanimously. The motion that the Model Variable Contract Regulation be adopted as a minimum uniform regulation was passed as amended.

The Chairman reported that the Subcommittee had been in contact with organizations which will develop questions for Variable Annuity examinations which can be made available to the individual States. It was moved and seconded that the Subcommittee recommend to the Executive Committee of NAIC that it make an urgent study of the possibility of obtaining professional help in preparing such examinations.

The Chairman reported that there are several problems still to be considered by the Subcommittee and the Industry Advisory Committee, particularly concerning methods of merchandising Variable Annuity Contracts, and that the Subcommittee and Industry Advisory Committee should be continued.

Hon. Robert D. Haase, Chm., Wis.; Hon. James H. Hunt, V.Chm., Vt.; Hon. Richard S. L. Roddis, Calif.; Hon. J. Richard Barnes, Colo. by Robert L. Brown; Hon. Albert F. Jordan, D. C.; Hon. Broward Williams, Fla.; Hon. Lorne R. Worthington, Iowa; Hon. Robert D. Preston, Ky.; Hon. C. Eugene Farnam, Mass.; Hon. David J. Dykhouse, Mich.; Hon. Charles R. Howell, N. J.; Hon. Richard E. Stewart, N. Y.

Note: List of States added for purposes of information.

Alabama	Florida	Louisiana	Montana	Oregon	Utah
Arizona	Illinois	Maine	Nevada	Rhode Island	Vermont
Arkansas	Indiana	Maryland	New Jersey	South Dakota	Virginia
California	Iowa	Massachusetts	New Mexico	Tennessee	West Virginia
Colorado	Kentucky	Michigan	Ohio	Texas	Wyoming
Connecticut					

## MODEL VARIABLE CONTRACT REGULATION

## ARTICLE I: AUTHORITY

Pursuant to authority given by Section \_\_\_\_\_ of the Insurance Laws of \_\_\_\_\_, the Insurance \_\_\_\_\_, after due notice and publication and after affording interested persons opportunity to present written data, views and arguments, does hereby make and promulgate the following rules and regulations to be applicable to insurance companies delivering or issuing for delivery in this state variable contracts pursuant to Section \_\_\_\_\_ of the Insurance Laws of this State.

These regulations shall become effective \_\_\_\_\_.

[NOTE: This Article will obviously depend on the existing provisions under a given state's insurance code with respect to the method for adopting rules and regulations.]

## ARTICLE II: DEFINITION

1. The term "contract on a variable basis" or "variable contract," when used in this Regulation, shall mean any policy or contract which provides for insurance or annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the insurer as to such policy or contract, as provided for in Section \_\_\_\_\_ of the laws of this State.

[NOTE: The objective here is to define the contracts covered by the regulations to include all forms of contracts which may be issued in connection with separate accounts authorized by the enabling statute (including group and individual, variable accumulation and variable benefit, etc.) Exclusion of particular kinds of contracts from sections of the regulation which may be inapplicable is handled in those sections.]

2. "Agent," when used in this Regulation, shall mean any person, corporation, partnership, or other legal entity which under the laws of this State is licensed as a life insurance agent, or solicitor, general agent, or life insurance broker.

[NOTE: States should make the necessary changes in terminology to conform with statutory language describing those persons eligible to be licensed to sell life insurance.]

3. "Variable contract agent," when used in this Regulation, shall mean an agent who shall sell or offer to sell any contract on a variable basis.

4. A "satisfactory alternative examination" to Part I of the written examination called for by paragraph 3 of Article IX shall include any securities examination which is declared by the Commissioner to be an equivalent examination on the basis of content and administration. The following examinations are deemed to be a satisfactory alternative examination:

- a. The State Securities Sales Examination;
- b. The National Association of Securities Dealers, Inc. Examination for Principals, or Examination for Qualification as a Registered Representative;
- c. The various securities examinations required by the New York Stock Exchange, the American Stock Exchange, Pacific Stock Exchange, or any other registered national securities exchange;
- d. The Securities and Exchange Commission test given pursuant to Section 15(b)(8) of the Securities Exchange Act of 1934;
- e. The examination recommended for the testing of variable contract agents by the National Association of Insurance Commissioners, when adopted by the Insurance Department of any State or Territory of the United States and approved for use by such Department by the Securities and Exchange Commission.

[NOTE: It is the intent of this Section to avoid duplication of effort and excessive burden and cost to the companies by recognizing the successful completion of any basic securities examination which satisfies federal security law requirements, as satisfying also the State's interest in testing basic securities knowledge as to variable contracts.]



## ARTICLE III: QUALIFICATION OF INSURANCE COMPANIES

## TO ISSUE VARIABLE CONTRACTS

1. No company shall deliver or issue for delivery variable contracts within this state unless (1) it is licensed or organized to do a life insurance or annuity business in this state; and (2) the Commissioner is satisfied that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the Commissioner shall consider among other things:

- (a) The history and financial condition of the company;
- (b) The character, responsibility and fitness of the officers and directors of the company; and
- (c) The law and regulation under which the company is authorized in the state of domicile to issue variable contracts.

2. If the company is a subsidiary of an admitted life insurance company, or affiliated with such company by common management or ownership, it may be deemed by the Commissioner to have satisfied the provisions of clause (2) of paragraph 1 hereof if either it or such admitted life company satisfies the aforementioned provisions; provided, further, that companies licensed and having a satisfactory record of doing business in this state for a period at least 3 years may be deemed to have satisfied the Commissioner with respect to clause (2) of paragraph 1 above.

3. Before any company shall deliver or issue for delivery variable contracts within this state it shall submit to the Commissioner (a) a general description of the kinds of variable contracts it intends to issue; (b) if requested by the Commissioner, a copy of the statutes and regulations of its state of domicile under which it is authorized to issue variable contracts and (c) if requested by the Commissioner, biographical data with respect to officers and directors of the company on the NAIC uniform biographical data form.

[NOTE: Paragraph 3 suggests the type of submission which might be appropriate to afford a basis for determining that a company meets the test in clause (2) of Paragraph 1.

Some state statutes provide seasoning requirements for the licensing of foreign life insurance companies; these statutes presumably will also apply to companies seeking to be licensed to sell variable contracts. The Committee does not believe that there is a need for seasoning requirements for companies writing variable contracts beyond those required for life companies generally. If, however, an additional seasoning requirement for companies writing variable contracts is considered desirable, the Committee feels that such a requirement should be specifically provided by statute and recommends that the statute expressly require consideration of the experience of a parent or affiliated company. See Paragraph 2 above.

The Committee recommends that if there are specific capital and surplus requirements for companies writing variable contracts, these should be the same as those for life insurance companies generally. If stricter capital and surplus requirements should be considered necessary, these should be specifically provided by statute and it is strongly recommended that the statute permit waiver of such requirements pursuant to rules and regulations duly adopted by the Commissioner. A regulation to accomplish this purpose might read as follows:

The Commissioner may waive any or all of the requirements set forth in Section \_\_\_\_\_ if by reason of a company's capital structure, surplus, amount of business in force and plan of operations, it substantially conforms to such requirements, or, in the opinion of the Commissioner, otherwise affords adequate protection to contract-holders.]

## ARTICLE IV: SEPARATE ACCOUNT OR SEPARATE ACCOUNTS

A domestic company issuing variable contracts shall establish one or more separate accounts pursuant to Section \_\_\_\_\_ of the Insurance Law of this State, subject to the following provisions of this Article:

1(a). Except as hereinafter provided, amounts allocated to any separate account and accumulation thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments

of life insurance companies; provided, that to the extent that the company's reserve liability with regard to (i) benefits guaranteed as to dollar amount and duration, and (ii) funds guaranteed as to principal amount or stated rate of interest is maintained in any separate account, a portion of the assets of such separate account at least equal to such reserve liability shall be, except as the Commissioner may otherwise approve, invested in accordance with the laws of this State governing the investments of life insurance companies. The investments in such separate account or accounts shall not be taken into account in applying the investment limitations applicable to the investments of the company.

1(b). With respect to 75% of the market value of the total assets in a separate account no company shall purchase or otherwise acquire the securities of any issuer, other than securities issued or guaranteed as to principal or interest by the United States, if immediately after such purchase or acquisition the market value of such investment, together with prior investments of such separate account in such security taken at market, would exceed 10% of the market value of the assets of said separate account; provided, however, that the Commissioner may waive such limitation if, in his opinion, such waiver will not render the operation of such separate account hazardous to the public or the policyholders in this state.

1(c). No company shall, whether for its separate accounts or otherwise, invest in the voting securities of a single issuer in an amount in excess of 10% of the total issued and outstanding voting securities of such issuer provided that the foregoing shall not apply with respect to securities held in separate accounts, the voting rights in which are exercisable only in accordance with instructions from persons having interests in such accounts.

1(d). The limitations provided in subparagraphs (b) and (c) above shall not apply to the investment with respect to a separate account in the securities of an investment company registered under the Investment Company Act of 1940, provided that the investments of such investment company comply in substance with subparagraphs (b) and (c) hereof.

[NOTE: Virtually all statutes contain the broad language in Paragraph 1(a) permitting investments without regard to investment limitations with respect to life insurance companies. Paragraph 1(b) would impose a quantitative limitation to promote diversification and limit investment risk. It should be noted that while separate accounts registered under the 1940 Act will be subject to the 5% rule under that Act, there would appear to be sound reasons for permitting greater flexibility, up to 10%, with respect to those separate accounts not so subject. It is further provided that the Commissioner may waive this limitation where such would not render the operation of the account hazardous.]

Paragraph 1(c) would prohibit acquisition of more than 10% of the voting securities of a single issuer, with the holdings by the company and all of its separate accounts aggregated, except when there is a pass-through of voting rights to contractholders.

Paragraph 1(d) is intended primarily to permit the operation of a separate account as a unit investment trust under the 1940 Act, with all of its assets being invested in the securities of a registered investment company. It should be noted, however, that the Commissioner would retain indirect control since the exception from the application of subparagraphs (b) and (c) would not apply if the investments of the investment company did not comply with such subparagraphs.

Basic authority for exemption from investment limitations, as well as the quantitative limitations in Paragraphs 1(b) and (c) and the exemption from these limitations in Paragraph 1(c), should probably be covered by statute.]

2. Unless otherwise approved by the Commissioner: assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to such separate account; provided, that the portion of the assets of such separate account equal to the company's reserve liability with regard to the benefits and funds referred to in clause (i) and (ii) of paragraph 1(a), if any, shall be valued in accordance with the rules otherwise applicable to the company's assets.

[NOTE: In the case of variable contracts involving 1940 Act registered account and in many group contracts the procedure for valuing assets will be stated in rules of the separate account or in a separate applicable written agreement, and the regulation is drafted to permit this.]

3. If and to the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

[NOTE: To achieve effective insulation of certain assets held in separate accounts from claims of general creditors it is probably necessary, as a matter of general corporate law, that such insulation be specifically authorized by statute.]

4. Notwithstanding any other provisions of law a company may

(a) with respect to any separate account registered with the Securities and Exchange Commission as a unit investment trust exercise voting rights in connection with any securities of a regulated investment company registered under the Investment Company Act of 1940 and held in such separate accounts in accordance with instructions from persons having interests in such accounts ratably as determined by the company, or

(b) with respect to any separate account registered with the Securities and Exchange Commission as a management investment company, establish for such account a committee, board, or other body, the members of which may or may not be otherwise affiliated with such company and may be elected to such membership by the vote of persons having interests in such account ratably as determined by the company. Such committee, board or other body may have the power, exercisable alone or in conjunction with others, to manage such separate account and the investment of its assets.

A company, committee, board or other body may make such other provisions in respect to any such separate account as may be deemed appropriate to facilitate compliance with requirements of any Federal or State law now or hereafter in effect; provided that the Commissioner approves such provisions as not hazardous to the public or the company's policyholders in this State.

[NOTE: Certain separate accounts are registered with the Securities and Exchange Commission under the Investment Company Act of 1940, and variable annuity contractholders in such separate accounts must be given voting rights, principally in connection with the management of the assets of the account. Paragraph 4(a) is intended to provide for a separate account registered with the SEC as a unit investment trust, under which all of the assets of the account are invested in a separate mutual fund. In this connection, see also Paragraph 1(d). Paragraph 4(a) would permit a pass-through of voting rights in the shares of the underlying mutual fund to the variable annuity contractholders.

Where a separate account is registered under the 1940 Act as a management investment company the variable annuity contractholders have the right to elect a Committee with power to manage the account and invest its assets. Paragraph 4(b).

As with the insulation provision in paragraph 3 of Article IV above, it would probably be wise in most states to provide authority for the above regulation by statute, since many states require that the assets of an insurer be managed by its board of directors.]

5. No sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account, is made (a) by a transfer of cash, or (b) by a transfer of securities having a valuation which could be readily determined in the marketplace, provided that such transfer of securities is approved by the Commissioner. The Commissioner may authorize other transfers among such accounts if, in his opinion, such transfers would not be inequitable.

[NOTE: This provision, common to many existing statutes and regulations, is intended to prevent unfair or discriminatory transfer among accounts. Regular cash flow should permit those transfers to and from the general account necessary to the operation of the variable contract business to be made in cash.]

6. The company shall maintain in each such separate account assets with a value at least equal to the reserves and other contract liabilities with respect to such account, except as may otherwise be approved by the Commissioner.

[NOTE: This section varies from a number of existing regulations which provide that assets shall be equal to reserves. The Committee agrees that a deficit should not be permitted, but that build-up of surplus within the separate account should not be prohibited as it would apparently be under the existing regulations referred to.]

7. Rules under any provision of the Insurance Law of this State or any regulation applicable to the officers and directors of insurance companies with respect to conflicts of interest shall also apply to members of any separate account's committee, board or other similar body. No officer or director of such company nor any member of the committee, board or body of a separate account shall receive directly or indirectly any commission or any other compensation with respect to the purchase or sale of assets of such separate account.

#### ARTICLE V: FILING OF CONTRACTS

The filing requirements applicable to variable contracts shall be those filing requirements otherwise applicable under existing statutes and regulations of this state with respect to individual and group life insurance and annuity contract form filings, to the extent appropriate.

#### ARTICLE VI: CONTRACTS PROVIDING FOR VARIABLE BENEFITS

1. Any variable contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of such variable benefits. Any such contract, including a group contract and any certificate issued thereunder, shall state that such dollar amount will vary to reflect investment experience and shall contain on its first page a clear statement to the effect that the benefits thereunder are on a variable basis.

2. Illustrations of benefits payable under any contract providing benefits payable in variable amounts shall not include projections of past investment experience into the future or attempted predictions of future investment experience; provided that nothing contained herein is intended to prohibit use of hypothetical assumed rates of return to illustrate possible levels of annuity payments.

3. No individual variable annuity contract calling for the payment of periodic stipulated payments shall be delivered or issued for delivery in this state unless it contains in substance the following provisions or provisions which in the opinion of the Commissioner are more favorable to the holders of such contracts:

(a) a provision that there shall be a period of grace of 30 days or of one month, within which any stipulated payment to the insurer falling due after the first may be made, during which period of grace the contract shall continue in force. The contract may include a statement of the basis for determining the date as of which any such payment received during the period of grace shall be applied to produce the values under the contract arising therefrom;

(b) a provision that, at any time within \_\_\_\_\_ year(s) from the date of default, in making periodic stipulated payments to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of such overdue payments as required by the contract, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness shall be applied to produce the values under the contract arising therefrom;

(c) a provision specifying the options available in the event of default in a periodic stipulated payment. Such options may include an option to surrender the contract for a cash value as determined by the contract, and shall include an option to receive a paid-up annuity if the contract is not surrendered for cash, the amount of such paid-up annuity being determined by applying the value of the contract at the annuity commencement date in accordance with the terms of the contract.

[NOTE: The Committee would recommend inclusion of provisions dealing with grace, reinstatement and non-forfeiture only if the law of a particular state requires these in individual fixed dollar deferred annuities. Several companies issuing variable annuity contracts do not require contractholders to make periodic stipulated payments. If a contractholder ceases making payments he may resume doing so thereafter at any time. It is assumed that Paragraph 3(a) would be inapplicable to such contracts since the provisions described above would be regarded as more favorable to the contractholders than a 30 day grace period.]

4. Any individual variable annuity contract delivered or issued for delivery in this State shall stipulate the expense, mortality, and investment increment factors to be used in computing the dollar amount of variable benefits or other contractual payments or values thereunder, and may guarantee that expense and/or mortality results shall not adversely affect such dollar amounts.

In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

(a) The annual net investment increment assumption shall not exceed 5%, except with the approval of the Commissioner;

(b) To the extent that the level of benefits may be affected by mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a higher mortality rate at any age, or, if approved by the Commissioner, from another table.

"Expense," as used in this paragraph, may exclude some or all taxes, as stipulated in the contract.

5. The reserve liability for variable annuities shall be established pursuant to the requirements of the standard valuation law in accordance with actuarial procedures that recognize the variable nature of the benefits provided.

#### ARTICLE VII: REQUIRED REPORTS

1. Any company issuing individual variable contracts providing benefits in variable amounts shall mail to the contractholder at least once in each contract year after the first at his last address known to the company, a statement or statements reporting the investments held in the separate account and, in the case of contracts under which payments have not yet commenced, a statement reporting as of a date not more than four months previous to the date of mailing, (a) the number of accumulation units credited to such contracts and the dollar value of a unit, or (b) the value of the contractholder's account.

2. The company shall submit annually to the Insurance Commissioner a statement of the business of its separate account or accounts in such form as may be prescribed by the National Association of Insurance Commissioners.

[NOTE: The Committee intended to leave this language sufficiently flexible to apply in the event that the separate account statement is combined with the regular life blank.]

#### ARTICLE VIII: FOREIGN COMPANIES

If the law or regulation in the place of domicile of a foreign company provides a degree of protection to the policyholders and the public which is substantially equal to that provided by these regulations, the Commissioner, to the extent deemed appropriate by him in his discretion, may consider compliance with such law or regulation as compliance with these regulations.

[NOTE: This blanket provision would permit a commissioner to waive any or all of those requirements applicable to foreign companies in cases where the quality of regulation in the state of domicile is such that he would have every reason to expect that the company would be adequately regulated.]

#### ARTICLE IX: EXAMINATION OF AGENTS AND OTHER PERSONS

1(a). No agent shall be eligible to sell or offer for sale a contract on a variable basis unless prior to making any solicitation or sale of such a contract, he also be licensed as a variable contract agent.

[NOTE 1: The inapplicability to home office employees of examination and licensing requirements with respect to life insurance shall equally apply to the sale of variable contracts. However in the event that a home office employee does possess a license to sell life insurance and variable contracts in a particular state, it is presumed that he possesses the same privilege as an agent has to sell variable contracts.]

[NOTE 2: State laws and regulations should permit variable contract agents to be licensed by the insurance company selling the variable contracts and also permit an affiliated or subsidiary company distributing the variable contracts as broker/dealer to receive commissions. The affiliated or subsidiary distributor frequently will be used by those insurance companies which plan to market both variable contracts and mutual funds through their own agency

forces; such distributor may distribute both the variable contracts and the mutual funds without multiple broker/dealer registration. State laws which prohibit incorporated general agencies or which prohibit a life company from owning a general agency should either be changed to permit the subsidiary or affiliated broker/dealer or be interpreted so as to not apply to subsidiary or affiliated broker/dealers which were not contemplated when the prohibitions were enacted into the state statute or regulation.]

1(b). Any agent who participates only in the sale or offering for sale of variable contracts that are not registered under the federal Securities Act of 1933 need not be licensed as a variable contract agent.

[NOTE: Under current regulations and interpretations of the federal securities acts, sales of certain variable group contracts meeting the terms of Rule 156 under the Securities Act of 1933 are not required to be registered under that Act. It is understood that this exemption may be expanded somewhat in the reasonably near future.]

2. Any agent applying for a license as a variable contract agent shall do so by filing with this Department "Uniform Form AP for Securities Salesmen, Variable Contract Salesmen and Other Associated Persons."

[NOTE 1: The form of Application referred to has been the subject of conversations and meetings with the SEC, with the purpose of agreeing on a standard form which could serve common purposes of (a) application to the state insurance department and (b) reporting form to the SEC and state securities department where applicable. This form would be a counterpart to and substitute for the present SECO-2 form of the SEC Personnel Form.]

[NOTE 2: An application for a license to sell life insurance and an application for a license to act as a variable contract agent may be made at the same time, and the examinations, if any, required for each license may be administered at the same time.]

3. The licensing as a variable contract agent of any agent complying with Paragraph 2 shall not become effective until such agent shall have satisfactorily passed a written examination upon securities and variable contracts. Such examination shall be divided into two parts. Part I shall be on securities generally. Part II shall deal with variable contracts, and shall be composed of at least fifteen questions, but not more than fifty questions, concerning the history, purpose, regulation, and sale of contracts on a variable basis.

4. The examination will be given in such places and at such times as the Commissioner shall from time to time designate. Upon application for license as a variable contract agent, the applicant shall be notified of the date of the next examination.

5. The examination recommended for the testing of variable contract agents by the National Association of Insurance Commissioners is hereby adopted for use in this State in its present form, or as it may be amended, and it shall be used in all tests given pursuant to this regulation.

[NOTE: Copies of the examination may be secured by an Insurance Department from the Executive Secretary of the NAIC. The NAIC examination, in two forms, should be filed with the Securities and Exchange Commission upon its adoption, if the Department has not previously done so. The submission of the forms for approval should be directed to: Chief, Branch of Non-NASD Regulation, Securities and Exchange Commission, Washington, D. C. 20549. At the same time, the SEC must be advised that a passing grade for each examination will be 70%, and that the examination will be conducted as a closed book, monitored examination. The security of these examinations is most important, and it may be necessary to revise the examinations from time to time to provide the maximum security. Any proposed change in either form must be submitted to the SEC and approved by it prior to use.

Variable contract agents taking the NAIC examination must achieve a minimum passing grade of 70% on the general securities portion of the examination (Part I) called for by the regulation. However, certain sales supervisory and home office employees are required to achieve a grade of at least 80% on this examination. The categories of persons required to achieve a grade of at least 80% will vary from company to company, depending upon the organization of the company and the manner in which it organizes its agency force.

It is the responsibility of the company to determine which persons must achieve the higher grade, and this regulation does not attempt to describe such persons. It is to be expected, however, that upon promotion or change of duties, certain applicants who have passed Part I of the examination with a grade of less than 80% may be required to retake that portion of the Department's examination to attain a higher passing grade.]

6. Any applicant for license as a variable contract agent shall not be required to take Part I of the NAIC examination if, at the time of application, evidence is presented that the applicant (a) has previously passed a satisfactory alternative examination as defined in Paragraph 4 of Article II of these Regulations, or (b) is currently registered with the federal Securities and Exchange Commission as a broker-dealer, or is currently associated with a broker-dealer and has met qualification requirements with respect to such association.

[NOTE: An "associated person," with respect to a registered broker-dealer securities firm, is a technical term defined in the federal securities laws. An "associated person" who is engaged directly or indirectly in the sale of securities, who supervises, recruits or trains such sales persons, is together with certain other home office personnel required to have passed a general securities examination, or alternatively must have been continuously in the securities business since July 1, 1963. This is also true of a person registered as a broker-dealer.

The federal securities laws and regulations specifically exempt a person from federal securities examination requirements if he was registered as a broker-dealer, or became an "associated person" prior to July 1, 1963, and has been continuously so registered or associated, and has not had any disciplinary sanction imposed on him by any federal or state securities agency or securities exchange or otherwise found to be a cause of any disciplinary action. It is not deemed necessary that such broker-dealer or persons be required to take the securities portion of the NAIC examination (Part I) because of their experience and record; however, it will be necessary that these persons take and pass Part II of the NAIC examination, with such additional questions appended thereto as a state insurance department may require.

It is contemplated that in most instances the insurance company with whom the applicant is to be licensed will submit a statement of the basis for any exemption claimed from the examination requirement, as in most cases this will be the only evidence available to the Department by reason of the manner in which test scores are reported by the SEC and the NASD. Their practice is to simply enter the grade on a return-address paper, and no other formal document is readily available to the applicant or the company.]

7. Every applicant applying for license as a variable contract agent shall satisfactorily complete Part II of the examination required by paragraph 3, with a grade of at least seventy percent (70%), or shall present evidence of successful completion of either a variable contract examination given under the supervision of an insurance department of any State or Territory of the United States which has adopted Part II of the examination recommended for the testing of variable contract agents by the National Association of Insurance Commissioners or has been examined and licensed by any such department prior to its adoption of the National Association of Insurance Commissioners Model Regulation.

[NOTE: Part II of the NAIC examination is not required to satisfy any federal or state law. This portion of the examination, dealing exclusively with variable contracts, is provided to test specific knowledge of the history, purpose and regulation of variable contracts over and above the general knowledge of the securities business required to pass Part I of the NAIC examination.]

8(a). Any applicant who fails to pass Part I of the examination required by paragraph 3 may not take Part I of the examination again until 30 days after initially taking it. After a second such failure, such applicant may not take the examination again until 60 days after taking the second examination. After a third and any subsequent such failure, such applicant may not take the examination again until 90 days after the third and any subsequent examinations.

8(b). Any applicant failing to pass Part II of the examination may take Part II again 20 days after the first and any subsequent examinations.

9. Every application for a license as a variable contract agent shall be accompanied by an examination fee of \$[\_\_\_\_\_]. A fee of \$[\_\_\_\_\_] will be charged for each re-examination administered to an applicant.

[NOTE: It is contemplated that the examination fee charged for an application for a license as a variable contract agent shall be an amount equal to the fee of a life insurance license.]

10. Report of the results of any examination given pursuant to this regulation shall be made by the Department on "Commissioner's Report of Examination No.-----," a copy of which is attached hereto as Exhibit A.

11. [OPTIONAL] Except as modified by these regulations, the regulations of this Department governing the licensing of life insurance agents including examinations therefor shall apply hereto.

12. Part I of the written examination provided for in Paragraph 3 shall also be administered to other persons who are not required to be licensed to sell life insurance in this State upon their submission of "Uniform Form AP for Securities Salesmen, Variable Contract Salesmen and Other Associated Persons" and payment of the examination fee.

[NOTE: As heretofore indicated under the Securities Exchange Act of 1934, it may be necessary for certain supervisory personnel and certain home office employees to be registered with the Securities and Exchange Commission even though they are not required to be licensed by State Insurance Departments as agents. The regulation authorizes the examination of such persons by the Insurance Department to enable them to comply with such federal requirements.]

13(a). Results of the examination administered pursuant to paragraph 3 will be reported by this Department to the applicant's company. In addition, examination results will be reported by this Department to any other State Insurance Department requesting confirmation of the examination grade, either upon request of such Department or upon request of the applicant or his company.

[NOTE: It is hoped that a uniform form for reporting results of an examination can be adopted by the various states which could serve the reporting functions outlined in this paragraph of the regulation. A copy of the suggested form is attached hereto as Exhibit A.]

13(b). [OPTIONAL] A charge of [50¢] shall be made for the second and each subsequent report of examination results.

14. Records of the examination grade of each applicant upon an examination administered by this Department, or upon an examination deemed to be a satisfactory alternative examination and administered by another agency or authority and reported to this Department, will be retained in the file pertaining to said applicant.

15. Any person licensed in this State as a variable contract agent shall immediately report to the Commissioner (a) any suspension or revocation of his variable contract agent's license or life insurance agent's license in any other State or Territory of the United States, (b) the imposition of any disciplinary sanction (including suspension or expulsion from membership, suspension or revocation of or denial of registration) imposed upon him by any national securities exchange, or national securities association, or any Federal, or State or Territorial agency with jurisdiction over securities or contracts on a variable basis; (c) any judgment or injunction entered against him on the basis of conduct deemed to have involved fraud, deceit, misrepresentation, or violation of any insurance or securities law or regulation.

16. The Commissioner may reject any application or suspend or revoke or refuse to renew any variable contract agent's license upon any ground that would bar such applicant or such agent from being licensed to sell life insurance contracts in this State. The rules governing any proceeding relating to the suspension or revocation of a life insurance agent's license shall also govern any proceeding for suspension or revocation of a variable contract agent's license.

17. Renewal of a variable contract agent's license shall follow the same procedure established for renewal of an agent's license to sell life insurance contracts in this State.



COMMISSIONER'S  
REPORT OF EXAMINATION NO. \_\_\_\_\_

STATE OF \_\_\_\_\_  
DEPARTMENT OF INSURANCE  
APPROVAL OF LICENSE AS A VARIABLE CONTRACT AGENT

\_\_\_\_\_  
Name of Applicant

When validated by the Department of Insurance, this will be your notice of approval of your qualification for a Variable Contract agent's license.

\_\_\_\_\_  
Address

Enter Name and Address of broker or dealer and of the company to which approval of Application for Variable Contract agent's license should be directed.

\_\_\_\_\_  
Broker-Dealer

LICENSE APPROVED

Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
(Commissioner-Superintendent-Director)

\_\_\_\_\_  
Company

TEST SCORE:—NAIC EXAMINATION

Securities PART I \_\_\_\_\_

Variable Contracts PART II \_\_\_\_\_

\_\_\_\_\_  
Address

(If Test Waived, Indicate Variable Contract Regulation Section Conferring Exemption)

\_\_\_\_\_  
If NAIC examination not taken, then name of General securities examination acceptable to the SEC.

\_\_\_\_\_  
TEST SCORE \_\_\_\_\_

Uniform Form AP for Securities Salesmen, Variable  
Contract Salesmen and Other Associated Persons

Filed with: U. S. SEC   
State of \_\_\_\_\_

(Submit in duplicate — SEE INSTRUCTION SHEET)

1. Name of Associated Person (Last, First, Middle)				2. Social Security Number	
3. Date of Employment		4. Position or Function		5. Part or Full-Time	Official Use
6. Date of Birth	7. Place of Birth	8. Length of Residence in the State in which you presently reside		9. Sex	10. Marital Status
11. State any name or names you ever used or by which you have been known					
12. State or states (including the District of Columbia) in which you are registered to engage in the securities business.					
13. State or states (including the District of Columbia) in which you are licensed to engage in the insurance business.					
14. Residence Address of Associated Person		Street	City	State	Zip Code
15. Business Address of Associated Person		Street	City	State	Zip Code
16. Name and main office Address of Principal		Street	City	State	Zip Code

If the answer to any of the following questions is "yes," give all pertinent details, including names and dates, and explain fully on an attached separate page.

- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| 17. Are you registered as a representative of a national stock exchange member?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you registered as a representative of an NASD member?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you previously taken an exam to be a securities salesman (agent) or dealer?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. If the answer to question 19 is "no," are you exempted from such examination requirement under Rule 15b8-1(a)(1)(A) under the Securities and Exchange Act of 1934? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you previously taken an exam to be an insurance salesman (agent)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you ever been denied authority to sell securities in any state or province?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Have you ever been denied authority to solicit, sell or broker insurance (whether life, property or other lines)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have you ever been given qualified authority to sell securities or insurance in any state or province?   | <input type="checkbox"/> | <input type="checkbox"/> |

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 25. Are you now or have you ever been subject to any revocation, cancellation, withdrawal, suspension, or any adverse order or directive of the NASD, any Canadian self-regulatory association, any securities exchange, or any state, provincial or federal agency which has the power to revoke, suspend or deny membership or registration?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are you now or have you ever been subject to any revocation, cancellation, withdrawal, suspension or any other adverse order or directive of any state insurance agency?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Have you ever been permanently or temporarily enjoined by any court from engaging in or continuing any conduct or practice involving any aspect of the securities business?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Have you ever been permanently or temporarily enjoined by any court from engaging in or continuing any conduct or practice involving any aspect of the insurance business?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Has any permanent or temporary injunction ever been entered into against you or any broker or dealer with which you were associated in any capacity at the time any such injunction may have been entered, involving the sale of securities?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Has any permanent or temporary injunction ever been entered into against you or any insurance company or agency with which you were associated in any capacity at the time any such injunction may have been entered, involving the sale of insurance?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Has any judgment been rendered against you in a civil action on the basis of any fraudulent acts in any transaction?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you within the last ten years been convicted of the commission of any crime or crimes other than minor traffic violations?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 33. Are any criminal charges pending against you?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. In your position with the principal firm, do you perform supervisory duties?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Have you ever previously engaged in selling securities or insurance as a dealer or salesman (agent)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Have you ever been suspended or barred from the practice of any profession?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Has any surety company paid out any funds on your coverage?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you or any organization owned or controlled by you or in which you were an officer, director, or partner ever been the subject of any insolvency or bankruptcy proceeding?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. List schools that you have attended beyond high school, the period of attendance, degrees received, if any, and any special courses of study pursued which are applicable to finance, securities or the insurance business.   |                          |                          |
| <hr/>   |                          |                          |
| <hr/>   |                          |                          |
| <hr/>   |                          |                          |
| 40. List employment history for the past 10 years, including any period of unemployment, showing the dates of employment, name and address of employer, type of business, your position, and your reason for leaving. If the space provided for answers to this question is insufficient, show complete answers on a blank form to be attached. |                          |                          |
| <hr/>   |                          |                          |
| <hr/>   |                          |                          |
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| <hr/>   |                          |                          |

TO BE EXECUTED BY THE ASSOCIATED PERSON (SALESMAN, AGENT)

I, the undersigned, have been appointed as an associated person (salesman, agent), and, being first duly sworn\*, depose and say: That I have read and carefully examined all statements made in this application and the exhibits attached hereto, and that each of such statements and representations are true and complete. I consent that notice of any proceeding before the Commission or Insurance Department may be given by sending notice by certified or registered mail or by confirmed telegram to the address given in Item 4 above.

\*Subscribed and sworn to before me, a notary public,

at \_\_\_\_\_ this \_\_\_\_\_ day \_\_\_\_\_ Signature of Associated Person  
of \_\_\_\_\_, A.D. 19\_\_\_\_\_. (Salesman, Agent)

(NOTARIAL SEAL) \_\_\_\_\_

\* \* \* \* \*

TO BE EXECUTED BY THE PRINCIPAL Appointment of Associated Person  
(Salesman, Agent) by Broker-Dealer  
or Issuer

The undersigned Principal, being first duly sworn\*, deposes and certifies:

1. That \_\_\_\_\_ is appointed as an associated person (salesman, agent);
2. That he (it) (where required by statute, rule or regulation) hereby applies for the registration and certification (licensing of the above named);
3. That he (it) believes the application form submitted herewith to be truthful in its entirety;
4. That he (it), on the basis of a due and diligent inquiry made of the background of the associated person (salesman, agent) named on this form and other information available, has reason to believe that such person is of good character and reputation and is qualified to perform his functions and duties as a person associated with this firm. Such person has fulfilled the appropriate examination requirements.

Principal's Name	Street	City	State	Zip Code
_____	_____	_____	_____	_____

Subscribed and sworn to before me, a notary public, By \_\_\_\_\_  
at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ Manual Signature Required  
\_\_\_\_\_, A.D. 19\_\_\_\_\_. Title \_\_\_\_\_

(NOTARIAL SEAL) \_\_\_\_\_

\*IF REQUIRED BY RULE, REGULATION OR STATUTE UNDER WHICH THIS APPLICATION IS FILED.

PROPOSED UNIFORM FORM AP  
FOR SECURITIES SALESMEN, VARIABLE ANNUITY SALESMEN  
AND OTHER ASSOCIATED PERSONS

General Instructions

1. To be executed in typewritten form, or printed legibly.
2. This form is to be used (1) for original applications for a state securities license or certificate and amendments thereto and for transfers from one broker-dealer or issuer-dealer to a new principal (2) for original applications for a state license to sell variable annuities and amendments thereto and (3) for original filings of the personnel form required by the SEC and amendments thereto.
3. Attach required exhibits.
4. Form AP cannot be accepted for filing unless it fully presents all information required. If an application is incomplete, it may be returned. All questions must be answered.
5. The term "Associated Person" is used herein to include "Agent" and "Salesman." The term "Associated Person" is defined in Rule 15b8-1(c)(2) under the Securities Exchange Act of 1934. The term "Issuer" is used herein to include either an investment company or an insurance company as the case may be.
6. No person shall act as an associated person until he has received a certificate (license) from the licensing authority.\* Such license or certificate is NOT EFFECTIVE when the associated person is NOT ASSOCIATED with the issuer or registered broker-dealer specified in his application or a notice filed with the Administrator-Commissioner. Upon the beginning or termination of employment with an issuer or registered broker-dealer, the associated person AND the issuer or broker-dealer shall promptly notify such Administrator-Commissioner; upon termination the associated person shall return his license to such Administrator-Commissioner.\*
7. The following exhibits should be attached:\*
  - A. A photograph of applicant taken within one year.
  - B. The required associated person's bond.
  - C. A check from the issuer or broker-dealer, or money order, in payment of filing fee.
  - D. An irrevocable consent to service of process.
  - E. A letter of clearance written by the last Principal who appointed the applicant to act as an associated person within the last ten years.
  - F. List of references.
8. In addition to the submission required to be made to the Securities and Exchange Commission under paragraph 3 below, this form must be submitted in duplicate to the state insurance department and state securities department of the state where the associated person is applying for a license to engage in the securities business or the variable annuity insurance business.
9. If the associated person applicant claims an exemption from the requirement of taking Part I of the NAIC written examination on securities and variable annuities, required by the variable annuity Regulations of the state insurance department, the applicant shall attach as an additional exhibit to this form evidence that he is entitled to one or more of the examination exemptions set out in such Regulations.

\*IF REQUIRED BY RULE, REGULATION OR STATUTE UNDER WHICH THIS APPLICATION IS FILED.

Instructions for Persons Filing Form AP  
in Satisfaction of SEC Requirements

1. This form must be filed by every non-member broker or dealer registered under Section 15 of the Securities Exchange Act of 1934 ("Act"), for every associated person engaged directly or indirectly in securities activities, for or on behalf of such non-member broker or dealer, before such person engages in any such activities on behalf of such nonmember broker or dealer.
2. This form must be accompanied by a filing fee of \$25 except in the case of (A) any Form AP filed on behalf of an associated person whose non-member broker or dealer employer has previously during his employment filed Form AP on his behalf and (B) any Form AP filed on behalf of an associated person who confines his securities activities to areas outside the jurisdiction of the United States, who does not deal with or act for any resident or national of the United States, and who has had Form SECO-2F submitted on his behalf in addition to Form AP.
3. This form must be submitted in duplicate to the Securities and Exchange Commission, 500 North Capitol Street N.W., Washington, D. C. 20549. Each copy submitted must be legible and originally executed.
4. The term "Associated Person" is defined in subparagraph (c)(2) of Rule 15b8-1. Associated persons subject to the examination requirement are described in subparagraph (a)(1)(A) of Rule 15b8-1.
5. If the space provided for any answer is insufficient, the complete answer should be prepared on a separate sheet which should be attached to the form and identified as "Answer to Item-----."
6. Pursuant to Rule 15b8-1, if the information contained in Form AP is or becomes inaccurate or incomplete for any reason, a new Form AP must be filed promptly by the nonmember broker or dealer correcting such information.
7. Failure to include or file information required to be reported or the making of any false statements may result in the institution of administrative or civil proceedings. Moreover, intentional misstatements or omissions of material facts constitute federal criminal violations punishable by up to five years imprisonment and fines up to \$10,000 for each offense. (See 18 U.S.C. 1001 and Section 32(a) of the Act.)

INFORMATIONAL MEMORANDUM  
 QUALIFICATION OF VARIABLE CONTRACT AGENTS

OUTLINE

- I. Introduction
- II. Licensing Procedures at Federal Level
  - a. NASD
  - b. SECO
  - c. Fees/Forms
- III. Variable Contract Examination
  - a. Form of Examination
  - b. Alternative Examination
  - c. Administration
- IV. Exemptions
  - a. Prior Qualification
  - b. Grandfathers' Clause

I

INTRODUCTION

The purpose of the provisions of Articles IX and X of the proposed Model Variable Contract Regulation is to establish a uniform procedure for the examination and licensing of those individuals who sell or offer to sell variable contract products as defined in the Regulations. For example, a person who sells variable annuities, flexible fund annuities or such other variable benefit annuities or life insurance policies as may now be available or developed in the future must comply with the provisions of this Regulation.

The Securities and Exchange Act of 1934 requires that certain sales, sales connected and supervisory personnel meet various qualification standards and this is accomplished by meeting the various registration and examination requirements of either the National Association of Securities Dealers (NASD) or the Securities and Exchange Commission's comparable organization (SECO). Registration of certain individuals may be necessary even though that person is not subject to the licensing rules as a variable contract agent under the applicable state statute or regulation of the state insurance department. Thus, the state insurance department should permit an individual to be examined upon request of his company notwithstanding the fact that such person does not have to meet any state requirement. Under NASD rules, certain managerial and supervisory personnel must take a special examination; under SECO rules, such personnel must achieve a higher score on the SECO examination.

It is the responsibility of the individual companies to determine which people within their organization are subject to the standards enunciated by either the SEC, NASD and the state insurance departments.

II

LICENSING PROCEDURES AT FEDERAL LEVEL

In addition to becoming registered with the Securities and Exchange Commission as a broker-dealer at the federal level, a company must subject itself either to the rules of the NASD or SECO. There is a difference between the two organizations as to which individuals must meet certain qualification standards and the following is an outline for each organization.

NASD

The NASD rule found in Schedule "C" of its By-Laws requires that all officers and individuals who are actively engaged in the management of the firm including supervision, solicitation, conduct of business or the training of persons associated with the firm must become registered as registered principals. This requires the passing of the

NASD's Qualification Examination for Principals. All employees, including assistant officers, who are engaged in the investment banking or securities business including supervision, solicitation or conduct of business or training individuals for any of these functions, must become registered as registered representatives and pass the NASD's Qualification Examination for Registered Representatives.

Individuals whose functions are solely and exclusively clerical or ministerial or who conduct business solely on an exchange or in either exempted securities or commodities are exempt from NASD registration.

There is a registration or filing fee with the Association of \$25 for all individuals required to be registered. The fees for taking the registered principal or registered representative examination are \$25 and \$20 respectively. Results of the examination are reported to the company by the NASD as either A, B, C, or Fail. No percentage score is given to anyone. An applicant who fails the examination may not take it again until thirty days have elapsed; those who fail in their second attempt must wait sixty days and finally, a ninety-day waiting period is required before each additional attempt if the test is failed a third time.

Individuals seeking to be registered with an NASD member firm must file the NASD Form A-300 which also includes the necessary admission certificate for sitting for an examination. Thus, in the case of a salesman, the firm completes A-300 and sends \$45 with the application. The results of the examination and notification of effective registration are sent to the firm by the Association.

An individual does not need to pass an examination if his most recent registration has not been terminated for a period of less than two years. Furthermore, any individual registered with the NASD on or before October 1, 1965 and designated as a principal is not required to take the principal examination. For example, a person who changes his association from one member to another has to file only a new A-300 to secure an effective registration.

#### SECO

The following individuals engaged in securities activities must pass a general securities examination: sales; trading; research or investment advice; advertising; public relations; hiring or recruitment of salesmen; training of salesmen; underwriting or private placements; and anyone who supervises others in such activities. Supervisory personnel must attain a score of 80% to qualify while others must score at least 70%.

SECO accepts the following examinations as a satisfactory alternative to the general securities examination (SECO) given by the Securities and Exchange Commission:

1. The NASD registered principal or registered representative examination.
2. State securities sales examination sponsored by the New York Stock Exchange.
3. The New York Stock Exchange registered representative or allied member examination.
4. The American Stock Exchange registered representative or partner examination.
5. The Pacific Coast Stock Exchange examination for registered representatives.
6. The State of Washington securities examination.
7. The National Association of Insurance Commissioners general securities examination.

The fee for taking the SECO examination is \$20. After an applicant has successfully passed an examination, his company must file SECO Form 2 with SECO accompanied by a filing fee of \$25. Thus, the total fee is \$45.

Any individual who has previously passed an acceptable examination or who has been continuously associated with an SEC registered broker-dealer since July 1, 1963 and has not been involved in any disciplinary sanction imposed on him by SEC, State Securities Agency or national securities exchange or association, need not take an examination if he changes employment. Of course, his company must file a SECO Form 2 accompanied by a fee of \$25.



## III

## VARIABLE CONTRACT EXAMINATION

Any individual who intends to sell variable contracts and who is required to meet qualification standards imposed upon him at either the federal or state level may satisfy those requirements by passing a written examination consisting of two parts. This examination is known as the NAIC - Variable Contract Examination. Part I shall be on securities generally and Part II shall be on variable contracts. Part II shall be composed of at least fifteen but not more than fifty questions concerning the history, purpose and regulation and sale of contracts on a variable basis.

The minimum passing score, in respect to Part I of the NAIC examination, shall be 70% in the case of salesmen (registered representatives) and 80% in the case of certain sales supervisory personnel and principals. This requirement is in harmony with the SEC requirement for SECO members. At the present time, those companies that join the NASD must have their agents pass the NASD registered representative or registered principal examination. However, before any agent can qualify to sell variable contracts within the state, that agent must pass Part II of the NAIC examination. Although the NASD does not grade the registered representative or principal examinations on a percentage basis, the minimum standards are comparable to those of SECO and NAIC. Thus, where an individual receives the minimum of C on the NASD examination, this should be considered by the (Commissioner-Director-Superintendent) as acceptable to him for purposes of Part I.

Most state securities departments which give examinations require that registered representative examinees attain a grade of at least 70%. However, since there is some variance in state securities department grading standards, and since some states do not examine principals, it will be necessary for the company to provide evidence of grading acceptability if a state securities department examination is to be relied upon in satisfaction of the requirements of Article IX, Section 4 of the proposed Regulations.

For purposes of satisfying the requirements of said Section of the Regulation the following examinations will be considered acceptable as Part I, dealing with securities generally:

1. The examination recommended for testing of variable contract agents by the National Association of Insurance Commissioners, when adopted by the insurance department of any state or territory in the United States and approved for use by such department by the Securities and Exchange Commission;
2. The Securities and Exchange Commission Examination (SECO) given pursuant to Section 15(b)(8) of the Securities Exchange Act of 1934;
3. The National Association of Securities Dealers, Inc. examination for principals or registered representatives;
4. The various securities examinations required by the New York, American, Pacific Coast and other securities exchanges registered under the Securities Exchange Act of 1934;
5. The State Securities Sales Examination.

Section 8(a) of Article IX of the Regulations requires retake waiting periods of 30, 60 and 90 days for Part I of the NAIC examination and this is done to keep the regulation consistent with Section 15(b)(8) of the Securities Exchange Act of 1934.

Part II of the NAIC examination shall have a passing score of 70%. If an applicant fails the examination, he must wait at least 20 days before sitting for it again. An individual may arrange to take the examination by having his company file Commissioners Application No. \_\_\_\_\_ accompanied by the appropriate fee. This is the proposed form referred to in Section 2 of Article IX of the Regulations and Note thereto. The (Commissioner-Director-Superintendent) will notify the company of the score attained by the applicant on the examination. It is understood that the SEC desires the state insurance department to notify the SEC directly of the score attained.

To insure the continued effectiveness and integrity of the examination, each (Commissioner-Director-Superintendent) should institute procedures which in his opinion may be necessary in order to maintain absolute security of the examination. Thorough proctoring of each examination is essential, particularly when large groups of examinees are tested at the same time. It is also advisable to limit access to examination material to only those staff members who are actually involved in the examination program.

Since examinations tend to lose their effectiveness after a prolonged period of exposure, it is intended that new examination forms will be developed from time to time. The NAIC stands ready to assist those state insurance departments with this function.

#### IV

#### EXEMPTIONS

In the interest of uniformity and to avoid duplication of examinations, each (Commissioner-Director-Superintendent) presumably will accept the successful completion of Part II of the examination given by another state insurance department when proper evidence of passing Part II can be shown by the applicant's company.

Likewise, an applicant who has previously been granted a variable contract license in any state should not be required to pass an examination even if the applicant was not required to pass an examination originally. In effect, Section 7 of Article IX of the Regulation provides an exemption from examination requirements for all those licensed before the examination procedure becomes mandatory. Similarly, there will be instances where a person has met the qualification requirements at the federal level of either SECO or the NASD without being required to take and pass a particular examination. It is submitted that the (Commissioner-Director-Superintendent) should accept evidence of a person's proper association with a SECO member as meeting examination requirements for licensing as a variable contract agent insofar as they apply to Part I of the NAIC examination. This is covered by SEC Rule 15(b)(8) under the Securities Exchange Act of 1934. Effective registration by a person with an NASD member company should also be accepted as meeting such Part I examination requirements. Of course, as previously stated, before any agent can qualify to sell variable benefit contracts within a state, he must pass Part II of the NAIC exam.

Satisfactory evidence of the passing of a prior acceptable examination or being previously licensed shall mean the furnishing to the department on Commissioner's Application No. \_\_\_\_\_ previously mentioned, a statement signed by a responsible official of the company indicating either the name of the examination which has been taken and the score attained or the state where licensed and period involved, or other grounds for exemption from the Part I NAIC examination.

Statement of Larry D. Gilbertson, Chairman  
Industry Advisory Committee on Variable Annuities  
to the (E6) Subcommittee  
June 17, 1968  
Portland, Oregon

On behalf of the Industry Advisory Committee, it is a privilege for me to present to you at this time the industry approved draft of regulations for the issuance and sale of variable contracts. Before making a few brief comments, I would like to thank the 20 members of this Committee for the enthusiastic cooperation which they have given and the contributions which they have made.

For the benefit of the members of your Subcommittee, I am submitting a list of the members of the Industry Advisory Committee, which will indicate not only the broad representation insofar as companies are concerned, but geographical representation as well.

We have had 8 meetings and have had, in my view, unprecedented attendance and participation. At no meeting were more than 3 of the members absent.

In developing the regulations, the Committee was divided into 2 groups — one to work primarily on the area of agent's examination and licensing — the other to concentrate on the qualification of companies and variable contracts. These subcommittees met both separately and jointly. I pay particular tribute at this time to Mr. Lloyd Ostlund of Investors Syndicate Life Insurance and Annuity Company, who Chaired the Agent's Examination and Licensing Subcommittee and Mr. John Kenney of the Travelers, who Chaired the other Subcommittee, relating to Company and Policy Qualification.

The Committee was appointed as of February 1 and Commissioner Haase charged the Committee to develop uniform regulations for consideration at this meeting. The regulations that you have before you at this time are the result of the deliberations of the Committee and, I believe I am authorized to say on behalf of the Committee, they have their full support.

As you will note, the regulations cover regulation of companies, regulation of contracts and policies, and examination of agents. I would like to emphasize that I would prefer to refer to the regulations as submitted to you as a variable annuity regulation or a regulation pattern. It must be recognized that at the present time there is no uniformity in the legislation and therefore there cannot be complete uniformity by regulation. However, we believe that in most instances a combination of your state law and a portion or all of these regulations will provide a degree of regulation which will provide a degree of regulation for the protection of the public which can be considered uniform.

I would like further to say that even though this is submitted in one document, it is separable — in other words, should you already have regulations insofar as companies and contracts are concerned, you may adopt only that portion relating to agent's examination and licensing — or any other portion.

It is our belief and hope that if we can establish a more uniform degree of regulation in the various states it will facilitate not only the operations of the companies but will assist the insurance departments in their regulation.

Ideally, it was agreed among the members of the Committee, we would not want regulation where regulation is not necessary. We believe it is the consensus of the Commissioners and the members of the Committee that at least as at this time some guidelines are necessary for the issuance of variable contracts. As you know, at the present time more than 30 states have already adopted the uniform variable annuity examination for the licensing of agents. I know of no other area of insurance regulation of insurance salesmen where there is comparable uniformity on the state level.

It is my personal belief that the adoption of these regulations by the states will provide additional support for the industry in attempting to resolve some of its problems on the federal level with the Securities and Exchange Commission.

In developing the regulations we received the support of the Subcommittee on Variable Annuities and Segregated Accounts of the Joint ALC-LIAA Actuarial Committee and a representative of their group is present in the event any members of the Subcommittee may have questions as to our report. I might add that most of the members of the Advisory Committee are also present and are available for comment.

I trust that the Subcommittee may take favorable action on the regulations as submitted as there are several states presently in the process of adopting regulations.

## Industry Advisory Committee

## NAIC Variable Annuity (E6) Subcommittee

- Larry D. Gilbertson, CHAIRMAN  
Senior Vice President & General Counsel  
Participating Annuity Life Insurance Co.  
8027 Leesburg Pike, McLean, Va. 22101
- Mr. William B. Brady, Legal Counsel  
The First Pyramid Life Insurance  
Company of America  
Pyramid Life Building  
Little Rock, Arkansas 72203
- Honorable C. Farris Bryant  
National Variable Annuity Company  
of Florida  
734 Florida National Bank Building  
Jacksonville, Florida 32202
- Mr. Samuel C. Cantor, Vice President  
& General Counsel  
The Mutual Life Insurance Company  
of New York  
1740 Broadway at 55th Street  
New York, New York 10019
- Mr. Richard J. Congleton,  
Senior Vice President  
External Affairs Department  
The Prudential Insurance Company  
of America  
Prudential Plaza  
Newark, New Jersey 07101
- Mr. Robert A. Crichton, Vice President  
& Special Counsel  
Variable Annuity Life Insurance Company  
of America  
1717 Pennsylvania Avenue, N. W.  
Washington, D. C. 20006
- Mr. Otis L. Frost, Jr., Vice President  
Occidental Life Insurance Company  
of California  
Occidental Center  
Hill and Olive at 12th Street  
Los Angeles, California 90054
- Mr. Clarence E. Galston, Executive  
Vice President & General Counsel  
Teachers Insurance and Annuity  
Association of America  
730 Third Avenue  
New York, New York 10017
- Mr. Manuel M. Gorman, Vice President  
& General Counsel  
Life Insurance Association of America  
277 Park Avenue  
New York, New York 10017
- Mr. Ralph L. Gustin, Jr., Senior Vice  
President & General Counsel  
John Hancock Mutual Life Insurance Co.  
P. O. Box 111  
Boston, Massachusetts 02117
- Mr. Edwin F. Jackson, General Counsel  
American Republic Insurance Company  
P. O. Box 10  
Des Moines, Iowa 50305
- Mr. John R. Kenney, Assistant Counsel  
& Assistant Secretary  
The Travelers Insurance Company  
One Tower Square  
Hartford, Connecticut 06115
- Mr. W. James McDonald, Counsel  
New England Mutual Life Insurance Co.  
501 Boylston Street  
Boston, Massachusetts 02117
- Mr. A. Warren McDougal,  
Associate Counsel  
The Paul Revere Life Insurance Company  
18 Chestnut Street  
Worcester, Massachusetts 01608
- Mr. C. Malcolm Moss, General Counsel  
American Life Convention  
211 East Chicago Avenue  
Chicago, Illinois 60611
- Mr. Robert W. Ninneman, Executive  
Assistant  
The Northwestern Mutual Life  
Insurance Company  
720 East Wisconsin Avenue  
Milwaukee, Wisconsin 53202
- Mr. Lloyd J. Ostlund, Vice President  
and General Counsel  
Investors Syndicate Life Insurance  
and Annuity Company  
Investors Building  
Eighth and Marquette  
Minneapolis, Minnesota 55402
- Mr. Henry O. Smith, Assistant General  
Counsel  
State Mutual Life Assurance Company  
of America  
440 Lincoln Street  
Worcester, Massachusetts 01605
- Mr. Davidson Sommers, Senior Vice  
President and General Counsel  
The Equitable Life Assurance Society  
of the United States  
1235 Avenue of the Americas  
New York, New York 10019
- Mr. Oliver M. Townsend, Vice President  
and General Counsel  
Continental Assurance Company  
310 South Michigan Avenue  
Chicago, Illinois 60604
- Mr. Kaye B. Wilson, Associate Counsel,  
Insurance  
American United Life Insurance Company  
P. O. Box 368  
Indianapolis, Indiana 46206

## NAIC Procedural Guide for Qualifying Variable Contract Annuity Agents

## Examination with Securities and Exchange Commission

The Securities and Exchange Commission is interested only in the portion of the examination dealing with securities. A state may use any variable annuities questions they desire — it is not necessary to receive SEC approval of the questions dealing with variable annuities. The Form A and Form B examinations which were furnished each state in April, 1966, include 50 questions on variable annuities which may be used in preparing an examination on this subject if you desire.

The procedure for developing the securities portion of a variable annuity agents examination follows:

1. Obtain copies of the NAIC variable annuity agents examination from the Executive Secretary of the NAIC. After June 23, only Form A (6-68) and Form B (6-68) of the examination will be furnished. Each of these contain 100 questions on securities which have been reviewed and approved by the Securities and Exchange Commission.

2. Submit the Form A (6-68) and Form B (6-68) examinations to

Mr. Thomas H. Monahan, Chief  
Branch of Non-NASD Regulation  
Division of Trading and Markets  
Securities and Exchange Commission  
Washington, D. C. 20549

3. Your transmittal letter should:

- a. Request approval to develop two examinations, using the questions from Form A (6-68) and Form B (6-68). Indicate that the questions in one examination will be those from Form A (6-68) but that the order of the questions will be varied periodically and the order of the answers for a question will be varied periodically. Likewise, indicate that the second examination will be developed from Form B (6-68) but that the order of the questions will be varied periodically and the order of the answers for a question will be varied periodically.
- b. Explain when and where the examinations will be administered.
- c. Describe the security regulations which will be followed in maintaining the security of the examinations.
- d. State that the examination questions will not be copied or left with the examinee and that there will be no review of the examination with the examinee.
- e. State that the securities portion of the examination will be graded separately and that the passing grade will be 70% for salesmen and 80% for general agents.
- f. Indicate that the examination will be a closed book examination.
- g. Indicate that you will follow the procedures established in the NAIC regulations for reporting results of examinations to the SEC.

MR. FAIRCLOTH: Mr. President, I know of no controversy and therefore I move the adoption of this report.

PRESIDENT BENTLEY: Is there a second?

COMMISSIONER HAASE: Second.

PRESIDENT BENTLEY: The motion is made and seconded that this report, in the absence of any controversy, be adopted. Is there objection to the adoption of this report? The Chair hears no objection and the report is adopted.

PRESIDENT BENTLEY: The (F) Committee on Property, Casualty and Surety Insurance; Mr. Don Knowlton of New Hampshire is recognized.

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PROPERTY, CASUALTY AND SURETY INSURANCE (F) COMMITTEE

AGENDA - MTG. #37

WEDNESDAY A.M.

JUNE 19, 1968

10:30-12:00

BALLROOM A

+Joint Meeting

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Reference

1968 Proc. VOL. I pp. 223-305

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1. Rates and Rating Organizations (F1) Subcom. Report (Mtg. 27)

Hon. Robert D. Haase, Chm., Wis.

Hon. Richard S. L. Roddis, V.Chm., Calif.

Refs: 1967 Proc. VOL. II p. 445 (additional references)  
 1967 Proc. VOL. II pp. 449-480  
 1968 Proc. VOL. I pp. 227-261

2. Unauthorized Insurers (F2) Subcom. Report (Mtg. 24)

Hon. Donald Knowlton, Chm., N. H.

Hon. Broward Williams, V.Chm., Fla.

Refs: 1967 Proc. VOL. II p. 445 (additional references)  
 1967 Proc. VOL. II pp. 481-484  
 1968 Proc. VOL. I pp. 263-266

3. Hurricane-Flood and Related Insurance (F3) Subcom. Report (Mtg. 11)

Hon. Broward Williams, Chm., Fla.

Hon. Charles R. Howell, V.Chm., N. J.

Refs: 1966 Proc. VOL. II p. 443 (additional references)  
 1966 Proc. VOL. II pp. 530-531  
 1967 Proc. VOL. I pp. 187-194  
 1967 Proc. VOL. II pp. 485-494  
 1968 Proc. VOL. I p. 267

4. Joint Industry Study of Mortgage Insurance Problems (F4) Subcom. Report (Mtg. 7)

Hon. Richard E. Stewart, Chm., N. Y.

Refs: 1966 Proc. VOL. II p. 443 (additional references)  
 1966 Proc. VOL. II pp. 532-533  
 1967 Proc. VOL. I pp. 195-199  
 1967 Proc. VOL. II pp. 495-496  
 1968 Proc. VOL. I pp. 269-274

5. Actuarial (F5) Subcom. Report (Mtg. 8)

Hon. David J. Dykhous by Robert A. Bailey, Chm., Mich.

Hon. Richard S. L. Roddis by Christy P. Armstrong, V.Chm., Calif.

Refs: 1966 Proc. VOL. I pp. 153-154  
 1966 Proc. VOL. II pp. 534-539  
 1967 Proc. VOL. I pp. 201-206  
 1967 Proc. VOL. II pp. 497-513  
 1968 Proc. VOL. I pp. 275-282

6. To Consider Premium Financing by Insurers (F6) Subcom. Report (Mtg. 12)  
 Hon. J. Richard Barnes, Chm., Colo.  
 Refs: 1967 Proc. VOL. I p. 175  
 1967 Proc. VOL. II pp. 447-448  
 1968 Proc. VOL. I pp. 283-284
7. +Additional Regulation of Special Property Coverages in connection with Installment Sales or Credit Transactions (F7) Subcom. Report (Mtg.+38)  
 Hon. J. Richard Barnes, Chm., Colo.  
 Ref: 1968 Proc. VOL. I p. 226
8. To Study Regulations of Financial Guarantees (F8) Subcom. Report (Mtg. 19)  
 Hon. Richard S. L. Roddis, Chm., Calif.  
 Ref: 1968 Proc. VOL. I p. 226
9. Definition and Interpretation of Underwriting Powers  
 (a) Classification of Fire, Marine and Casualty Insurance  
 Industry Committee Report — Joseph G. Bill, Executive Secretary  
 Refs: 1966 Proc. VOL. II p. 444 (additional references)  
 1966 Proc. VOL. II p. 445 NR  
 1967 Proc. VOL. I p. 175 NR  
 1967 Proc. VOL. II p. 514  
 1967 Proc. VOL. I p. 225 NR
- (b) Interpretation of Nation-Wide Marine Definition  
 Industry Committee Report — Joseph G. Bill, Executive Secretary  
 Refs: 1966 Proc. VOL. II p. 444 (additional references)  
 1966 Proc. VOL. II p. 538  
 1967 Proc. VOL. I p. 207  
 1967 Proc. VOL. II p. 515  
 1968 Proc. VOL. I p. 225
10. Aircraft Insurance — Policy Provision and Underwriting  
 Refs: 1960 Proc. VOL. I pp. 97-105  
 1967 Proc. VOL. II pp. 447; 516-518  
 1968 Proc. VOL. I p. 225
11. Federal Crop Hail Insurance  
 Refs: 1967 Proc. VOL. I pp. 224-225; 226; 230-231  
 1967 Proc. VOL. II p. 448  
 1968 Proc. VOL. I p. 225
12. Automobile Assigned Risk Plans — Elimination of State Managers and State Governing Committees (Oregon).
13. Any other matter submitted for consideration.
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PROPERTY, CASUALTY AND SURETY (F) COMMITTEE  
Report (Mtg. 37)

The COMMITTEE met in Portland, Oregon on Wednesday, June 19, 1968 in the Portland Hilton Hotel with a quorum present. The matters on the agenda were given consideration as follows :

1. Rates and Rating Organizations (F1) Subcommittee Report. This Report was submitted by the Chairman of the Subcommittee, the Honorable Robert D. Haase, Commissioner, Wisconsin, and was adopted. A copy is attached and made a part of this Report.
2. Unauthorized Insurers (F2) Subcommittee Report. This Report was submitted by Donald Knowlton, the Chairman of the Subcommittee, and was adopted. A copy of this Report is attached and made a part hereof.
3. Hurricane-Flood and Related Insurance (F3) Subcommittee Report. This Report was presented by the Honorable Broward Williams, Commissioner of Florida, and was adopted. A copy is attached to this Report and made a part hereof.
4. Joint Industry Study of Mortgage Insurance Problems (F4) Subcommittee Report. This Report was submitted by the Chairman of the Subcommittee, the Honorable Richard E. Stewart, Superintendent, New York, and was adopted. A copy is attached and made a part of this Report.
5. Actuarial (F5) Subcommittee Report. This Report was submitted by the Chairman of the Subcommittee, the Honorable David J. Dykhouse, Commissioner, Michigan, and was adopted. A copy is attached to this Report and made a part hereof.
6. To Consider Premium Financing by Insurers (F6) Subcommittee Report. This Report was submitted by the Chairman of the Subcommittee, the Honorable J. Richard Barnes, Commissioner of Colorado, and was adopted. A copy is attached to this Report and made a part hereof.
7. There was a misunderstanding with respect to the responsibilities of the Subcommittee to study the question of Additional Regulation of Special Property Coverages in connection with Installment Sales or Credit Transactions (F7). It appeared that there are some problems for this Subcommittee to consider in the future and, therefore, it was recommended that the Subcommittee be continued.



8. To Study Regulations of Financial Guarantees (F8) Subcommittee Report. This Report was submitted by the Chairman of the Subcommittee, the Honorable Richard S. L. Roddis, Commissioner of California, and was adopted. A copy is attached to this Report and made a part hereof.
9. The matters dealing with the Definition and Interpretation of Underwriting Powers, namely, (A) the Classification of Fire, Marine and Casualty Insurance Industry Committee Report, and (B) Interpretation of Nation-Wide Marine Definition Industry Report were presented by Mr. Joseph G. Bill, and the Reports were adopted.
10. There appeared to be no further interest in the problems in connection with Aircraft Insurance and, therefore, the item of Aircraft Insurance — Policy Provisions and Underwriting was removed from the agenda.
11. There appeared to be no interest in the item of Federal Crop Hail Insurance and, therefore, this item was removed from the agenda.
12. Automobile Assigned Risk Plan — Elimination of State Managers and State Governing Committees (Oregon). This matter, together with problems concerning the placing of automobile insurance, was discussed by Commissioner Williams of Florida and a representative of the Oregon Department. The Committee voted to establish a Subcommittee to be designated as Subcommittee To Consider Facilities for Placing Automobile Insurance with a recommendation that these matters be considered by this Subcommittee.

There being no other matters submitted for consideration, the meeting adjourned.

Hon. Donald Knowlton, Chm., N. H.; Hon. Broward Williams, V.Chm., Fla.; Hon. Walter S. Houseal, Ala.; Hon. Richard S. L. Roddis, Calif.; Hon. J. Richard Barnes, Colo.; Hon. James L. Bentley, Ga.; Hon. Edwin H. Honda, Hawaii; Hon. John R. Blaine, Idaho; Hon. Lorne R. Worthington, Iowa; Hon. Dudley A. Guglielmo, La.; Hon. David J. Dykhouse, Mich.; Hon. Thomas C. Hunt, Minn.; Hon. Robert D. Scharz, Mo.; Hon. Elmer V. Omholt, Mont.; Hon. Richard E. Stewart, N. Y.; Hon. Edwin S. Lanier, N. C.; Hon. Charles W. Gambrell, S. C.; Hon. Warren E. Dirks, S. D.; Hon. Ned Price, Texas; Hon. Frank R. Montgomery, W. Va.; Hon. Robert D. Haase, Wisc.

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Rates and Rating Organizations (F1) Subcom. Report  
(Mtg. 27)

The Rates and Rating Organizations (F1) Subcommittee met in Ballroom B of the Portland Hilton Hotel at 3:30 P.M., June 17, 1968.

The Report of the Subcommittee To Review Statistical Plans (F1a) was read in open session and received by the Subcommittee. It was noted that the (F1a) Subcommittee has completed its consideration of the items on its agenda and should be discharged subject to being reactivated at such time as agenda items would be assigned to it. In Executive Session the Report of the (F1a) Subcommittee was adopted and made a part of this Report.

The Chairman reported on the status of the activity of the Subcommittee in its study and analysis of the Rate-Regulatory Statutes. The Subcommittee had originally scheduled an open hearing in Chicago for April 24, 25 and 26, 1968. This Meeting was cancelled and has been re-scheduled for July 17, 18 and 19, 1968, at the Palmer House, Chicago, Illinois. The Meeting was postponed until this date at the request of interested persons in the Insurance Industry who were unable to devote the necessary time to the preparation of written statements because of the work associated with Congressional hearings and allied questionnaires. The Chairman stated that it is the intent of the Subcommittee to suggest modifications or changes, if any, in the NAIC All-Industry Rate Regulatory Statute as a result of its current study.

It was pointed out that there is a possibility that Senator Hart may have scheduled hearings before his Congressional Committee for the dates mentioned. The Subcommittee will attempt to resolve such a schedule conflict if it exists but was of the opinion that the July 17-19 Meeting should be held if at all possible.

There were no other matters submitted for consideration.

Hon. Robert D. Haase, Chm., Wis.; Hon. Richard S. L. Roddis, V.Chm., Calif.; Hon. Broward Williams, Fla.; Hon. Lorne R. Worthington, Iowa; Hon. Dudley A. Guglielmo, La.; Hon. Louis T. Mastos, Nev.; Hon. Donald Knowlton, N. H.; Hon. Richard E. Stewart, N. Y.; Hon. Eugene P. Brown, Ohio; Hon. Ned Price, Tex.; Hon. Nelson Parker, Va.

To Review Statistical Plans (F1a) Subcom. Report  
(Mtg. 2)

The (F1a) Subcommittee To Review Statistical Plans met in Parlor "E" of the Portland Hilton Hotel at 2:30 p.m., June 16, 1968.

The matter of the effect of individual risk rating programs on statistical plans was discussed in open session. At the request of the Chairman, comments from representa-

tives of industry were made in respect to agenda items for future meetings and in respect to the continued existence of the Subcommittee.

One representative of the insurance industry called to the attention of the Subcommittee the interest of the Federal Government in statistical information on fire losses under a new act involving fire risk and safety codes. It was suggested that this may be a matter for future liaison with the Federal Government and organizations such as the National Fire Protection Association, National Insurance Actuarial and Statistical Association, and the NAIC in order to effect some measure of uniformity in the collection of such statistical information on fire losses.

The Subcommittee considered these matters in Executive Session. It was concluded that no further action was necessary at this time in respect to the effect of individual risk rating programs on statistical plans.

The Subcommittee took note of the fact that due consideration has been given to each of the agenda items before the Subcommittee and that no additional items have been submitted for consideration by the Subcommittee. It was the consensus of the members of the Subcommittee that it should report to its parent (F1) Subcommittee, that consideration has been given to all agenda items and that it recommends the (F1a) Subcommittee To Review Statistical Plans be discharged subject to being reactivated at such time that specific agenda items would be assigned to it.

Hon. Robert D. Haase, Chm. by Stanley C. Du Rose, Wis.; Hon. Broward Williams by Samuel Rogers, Fla.; Hon. Lorne R. Worthington by E. Arnold Smith, Iowa; Hon. David J. Dykhouse by William H. Larsen, Mich.; Hon. Charles R. Howell by Horace J. Bryant, Jr., N. J.; Hon. Richard E. Stewart by Jacob Malmuth, N. Y.; Hon. Eugene P. Brown, Ohio; Hon. Lee I. Kueckelhan by William D. Yerkes, Wash.

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## Unauthorized Insurers (F2) Subcom. Report

(Mtg. 24)

The (F2) Subcommittee met at the Portland Hilton Hotel in Portland, Oregon on Monday, June 17, 1968 with a quorum present. The Executive Director, Joseph A. Humphreys, presented a report on the operations of the Non-Admitted Insurers Information Office, and described the latest developments noted in activities of fraudulent non-admitted insurers.

At the NAIC meeting held in Hawaii representatives of surplus lines buyers associations noted that the copyright provisions surrounding listings of alien insurers distributed by the Non-Admitted Office prevented circulation of such information to members of their associations, and asked the Subcommittee to consider a means of effecting a wider distribution which would also increase the financial income of this office. The Executive Director was asked to make a study of this subject, and recommended an amendment to the Plan Of Operation which would accomplish the end desired. Upon motions made and accepted this amendment was adopted.

The Executive Director related experience encountered in applying the provisions of the Plan Of Operation relating to appeals upon refusal to list certain alien insurers. As a result of this experience he recommended an amendment to the Plan Of Operation in Section V by the inclusion of new terminology. Upon motions made and seconded these amendments were adopted.

The Executive Director reported some difficulties of identification by alien administrators and industry officials due to the fact the word "non-admitted" included in the title of this office was not translatable. The Executive Director recommended that the title of the office be changed from the Non-Admitted Insurers Information Office to Alien Non-Admitted Insurers Information Office. After discussion, on motion made and seconded, this amendment was adopted.

In the executive session of this Subcommittee meeting the Executive Director described future possible uses of the Information Office for the purposes of disseminating additional information to the various State Insurance Departments. It was moved and seconded that the recommendations of the Executive Director on this subject be brought to the attention of the Executive Committee.

It was moved and adopted that the operation of the Non-Admitted Insurers Information Office be continued on the present basis and under the present arrangement with the Valuation of Securities Office, and that Mr. Humphreys be retained as Executive Director. This action to be effective until the June 1969 Meeting of NAIC.

There being no further items on the agenda the meeting of the Subcommittee was adjourned.

Attached and made part of this report is a copy of the Executive Director's report which contains text of the amendments adopted.

Hon. Donald Knowlton, Chm., N. H.; Hon. Broward Williams, V.Chm., Fla.; Hon. Richard S. L. Roddis, Calif.; Hon. J. Richard Barnes, Colo.; Hon. John F. Bolton, Jr., Ill.; Hon. Dudley A. Guglielmo, La. by F. J.; Hon. Frank M. Hogerty, Jr., Maine, Hon. Richard E. Stewart, N. Y.; Hon. David O. Maxwell, Pa.

June 17, 1968

Honorable Donald Knowlton, Chairman  
Unauthorized Insurance Subcommittee  
National Association of Insurance Commissioners

Dear Mr. Chairman:

On this Fifth Anniversary of the founding of the NAIC Non-Admitted Insurers Information Office, it appears appropriate to re-examine the accomplishments of this office and attempt to predict its future uses in the years to come.

The advisability of forming this office obtained universal approval in 1963 from the then Insurance Commissioners who at that time were considering attempts to develop a uniform approach for the improvement of country-wide surplus lines regulation.

As our basic assignment was to open up new lines of communications between the States, the industry and the public to hopefully afford better protection for both large and small surplus lines buyers, our efforts have been concentrated in this direction.

At the outset, we carefully felt our way through anticipated, but never realized alien insurer opposition to any form of United States regulation, while scrupulously refraining from forcing supra regulatory views on any State Insurance Commissioner. Thus we have been fairly successful in finding a non-controversial way to effectively occupy what was a yawning gap in state regulation. How long we will be able to occupy this field depends on a number of choices to be made in the future.

It was plain that the first move into the gap area was the establishment of a country-wide surplus lines informational link to erase this long overdue communications lack. I earnestly believe we have accomplished this on a satisfactory basis despite extremely limited financing. This office has not only provided listings of eligible alien insurers and reinsurers plus other incidental services, but as well through research has exposed and constantly apprised Insurance Commissioners and Federal Agencies alike of surplus lines abuses perpetrated by an irrepressible minority of what is a most reputable part of the great insurance industry.

It would be a most pleasant task for me to report at this date that abuses in surplus lines are under control. Unfortunately, the more you probe into this gray area of deceit and fraud, the more work appears cut out for Insurance Commissioners. From information constantly reported to this office, it is apparent that our continued warnings to Insurance Commissioners may not be getting to the ears of both sophisticated and unsophisticated brokers in the hinterlands of the United States. While many states are now aggressively active in policing this field of surplus lines abuse, it appears in the great majority of smaller states their uninformed brokers are still easy marks for even the most ordinary surplus lines "Flim-Flam" operator.

The surplus line "Flim-Flam" man of yesteryear was bad enough, but at least he conducted his subversion within the framework of known insurance operational limits. The 1968 model of the surplus lines "Flim-Flam" man is of an entirely new breed who is blithely prepared to plunge into every "Holding Company," "Mutual Investment Fund Affiliation" and even a "Merger" opportunity because all these new trends, seemingly adopted by the reputable insurance industry, are tailor-made bonanzas for his deceptive operations.

The 1968 "Flim-Flam" man does not use the open approach employed by his predecessors. He is still selling the same old "Paper" alien insurer with a "Paper" trust fund but he has become an ardent and skilled undercover insurance operator, prepared to take full advantage of businesses with non-insurance titles or disguised corporate covers to help sell his easily vanishing insurance wares. As well oriented corporate paper jugglers, they are now adept, inventive and above all aggressive salesmen. However, they may be also and often trapped in the mire of multiple paper corporations they have cast aside in attempts to throw dust in the eyes of regulators. On occasion some such "paper" trails would appear ample enough to support a charitable waste paper drive but ironically such operators seldom stop to record on paper claims they receive from hapless policyholders who occasionally may pierce the anti-claim protective shields they build. One outstanding 1968 "Flim-Flam" man talked a domestic insurer's agent into accepting "Reinsurance" of an alien "Paper" insurer despite the fact the agent had no authority to do so.

While I am reading this report to you, an unusually large group of "Merged" alien paper type insurers, replete with "Holding companies," paper "Trust" funds and non-insurance titled corporate disguises, continues to aggressively solicit surplus lines in the United States in defiance of overworked State Insurance Commissioners and Federal Agencies as well. Recent reports indicate another of their non-insurance titled corporate creations is soliciting surplus line brokers and agencies offering "Area" appointments as "Managers" not agents. You would think that the clearly non-insurance corporate titles used would alert these prospective "Area Managers," but apparently brokers and agents overlook this vital fact while responding favorably to the same old higher commission sales pitch they have always used.

Despite early warnings against such alien insurer operations mailed regularly by this office to State Insurance Commissioners, such insurers seem to successfully elude prosecution. The reported increased infiltration of United States Business corporations by criminal elements is bound to also affect this type of the insurance industry. Alien "Paper" and sometimes U. S. domestic insurers are most eligible targets for takeover by the 1968 "Flim-Flam" man who incidentally is not immune to invasion from other elements who may at any time seize "Key Man" insurance on his "Paper Life."

Insurance Commissioners must use every means to combat the increasing use of non-insurance titled corporations designed to cover illegal solicitation of all lines of insurance and must constantly warn brokers and agents in their jurisdictions to report solicitations from such questionable sources which contact them from out of state and are not known to them personally.

At previous meetings of the Subcommittee, representatives of insurance buyers associations have recommended adoption of means by which listings of eligible alien insurers now distributed quarterly to subscribers, could be duplicated and distributed to members of their associations at a more reasonable cost than presently available to them. Any method which will preserve the copyright and confidentiality of these listings and at the same time spread this vital information to increased numbers of buyers in the United States is worthy of consideration.

Accordingly, I recommend that your Subcommittee consider changing our plan of operation to include the following two amendments: —

No. 1 Amend the Plan of Operation by adding the following paragraph:

VII. Listing subscribers in good standing, who represent established trade or other associations, may upon written request, obtain permission to duplicate and circulate for use of their membership only, additional copies of each listing, or supplement, upon payment, in addition to their regular annual subscription fee of \$75, an additional \$100 extended distribution fee, plus a \$1 additional fee per each listing copy circulated in excess of the first fifty copies. Associations having large memberships may contact the Non-Admitted Insurers Information Office regarding special reduced bulk listing copy fees.

Experience in applying the provisions of the Plan of Operation relating to rights of appeal available to alien insurer applicants who have been refused listing, has resulted in my recommending this provision be amended by adopting the following amendment: —

No. 2. Amend the Plan of Operation by striking out Section V and inserting in place thereof the following:

V. Any alien insurer or reinsurer dissatisfied by the failure of the representative of the Subcommittee to include its name on the list as provided in paragraph III, shall upon application, be entitled to an appeal and a hearing before three members of the Unauthorized Insurance Subcommittee. Such appeal must be made in writing within sixty (60) days after receipt of notice by the insurer that its application for listing has been rejected and shall include an

agreement by the appellant to submit to an examination of its affairs if deemed necessary by the Chairman of the Subcommittee and pay the expense of such examination. If the appellant fails to prosecute its appeal within sixty (60) days from date of filing, the appeal shall be considered waived and the Chairman of the Subcommittee shall so notify the appellant. No appellant whose application has been rejected or withdrawn shall file another application until two years from the date of such rejection or withdrawal.

Respectfully submitted,

Joseph A. Humphreys  
Executive Director  
Non-Admitted Insurers  
Information Office

Hurricane-Flood and Related Insurance (F3) Subcom. Report  
(Mtg. 11)

Hurricane-Flood and Related Insurance (F3) Subcommittee met in Portland, Oregon on June 17 at 10:00 a.m., and the following Insurance Commissioners and Deputies were present:

Broward Williams, Chairman — Florida  
Charles R. Howell, Vice Chairman — New Jersey  
Dudley A. Guglielmo — Louisiana  
Frank M. Hogerty, Jr. — Maine  
Ned Price — Texas

Commissioner Williams rendered the following report.

“Our flood insurance bill S.1985 is still alive and has been included in an Omnibus Housing Bill S.3497 by the United States Senate. As you may know, the Omnibus Housing Bill is a multi-headed piece of legislation that also includes crime and riot insurance. The package bill, managed by Senate Banking and Currency came out of the Subcommittee and out of the Committee without difficulty and in the last week in May it was passed by the Senate by vote of 67 to 4. While there were some amendments to the Omnibus Housing portion of the bill, the flood insurance section remained unchanged and is still on the basis of Treasury borrowing, or as it is sometimes called — ‘back door financing.’

However, a different situation obtains in the House of Representatives where the committee on Banking and Currency has been holding *closed sessions*. However, the bill was to have been reported out of a Subcommittee possibly by June 12th and be ready to be sent to the Floor shortly thereafter.

At the moment, it is almost certain that flood insurance will not be included in the House version but there may be an attempt to put it in the bill when it comes up for a vote in the House. It should be of interest to you to note that the House version of Omnibus Housing and Crime and Riot, is on the basis of *Treasury borrowing* the very thing that gave us so much difficulty when our flood bill went to the House last year.

We are informed that Congressman Patman has indicated that he will go along with the crime and riot section and we are also informed that Congressman Mahon of Texas has likewise agreed to go along although the bill is on the basis of back door financing which is apparently contrary to his philosophy. We have been informed with considerable degree of



reliability that Congressman Mahon will not go along with flood insurance if it is included in the House package, and in fact, we understand he will work against it.

Regardless of all of this, the two versions will have to go to conference so that their differences may be resolved. It is in conference that we hope that the Senate version will prevail. At the moment, it is our feeling that the Senate will prevail. In any event, the bill will go back to the two Houses to be voted on an up or down basis and no amendments are then permitted. While we are not out of the woods, the possibility of enactment of our flood bill at this session appears to be more favorable.

While we would prefer that our flood bill travel under its own banner, we will welcome it as part of the package. It will enable us and the insurance companies to get the store open or to say it another way, to get the show on the road. There will always be floods and flood disasters. We would like to see our people be permitted to purchase flood insurance and not have to depend on government handouts.”

Mr. John Neville of American Insurance Association was called upon to express any opinions that he may have had on the above subject, and he very kindly referred to Mr. Maurice Herndon of Washington, D. C. who represents the National Association of Insurance Agents, and suggested to Commissioner Williams that Mr. Herndon be invited to express his comments, which he did. Mr. Herndon's comments agreed with those contained in the above report, and he went on to say that the position of the flood insurance bill appears to be more favorable than ever before.

Commissioner Williams took the occasion on the behalf of the entire Subcommittee to express his sincere thanks for the excellent cooperation that was being received from all segments of the industry. He noted that the report was brief but much work was being done by the industry to implement the flood program just as soon as the necessary legislation was enacted by the Congress.

Hon. Broward Williams, Chm., Fla.; Hon. Charles R. Howell, V.Chm., N. J.; Hon. Richard S. L. Roddis, Calif.; Hon. John F. Bolton, Jr., Ill.; Hon. Dudley A. Guglielmo, La.; Hon. Frank M. Hogerty, Jr., Me.; Hon. Charles W. Gambrell, S. C.; Hon. Ned Price, Texas.

## Joint Industry Study of Mortgage Insurance Problems

## (F4) Subcom. Report (Mtg. 7)

The (F4) Subcommittee met at 9:00 A.M. on Monday, June 17, 1968, in Galleria #2 of the Portland Hilton Hotel, Portland, Oregon. A quorum was present.

In the absence of Mr. John P. Burke, Chairman, Mr. William M. Anderson, Assistant Executive Secretary of the National Association of Insurance Agents, vice chairman of the Joint Industry Advisory Committee, read the report of the Committee which described developments since the December, 1967 meeting of the Subcommittee held in Honolulu, Hawaii.

Mr. Anderson stated that in reviewing the Proceedings of the regular meeting of the National Association of Insurance Commissioners in Hawaii in December of 1967, the Committee had discovered an error with respect to a report of joint action taken by the Texas Mortgage Bankers Association and the Texas Association of Insurance Agents. As entered, the Proceedings indicated that all of those national organizations comprising the Joint Industry Advisory Committee To Study Mortgage Industry Problems participated in the development of the recorded statement. He pointed out that while the National Advisory Committee commended the Texas organizations for their action to endorse mutually agreed practices, the statement was not identical to that which his Committee developed. He requested that the record should be corrected to show that the National Committee had not participated in the development of the Texas document.

Mr. Anderson reported that the several organizations represented on the National Committee had been engaged in obtaining endorsements and local implementation of the principles contained in the Statement, and that this effort was meeting considerable success with both National and Local Insurance Producers, Insurance Companies and Mortgage Lending Groups. He referred to a letter from the United States Savings & Loan League, dated June 14, 1968, reporting that the Statement of Recommended Insurance Practices of the Mortgage Lending and Insurance Businesses had been adopted by the various State Savings & Loan Leagues and the statement implemented by the great majority of them among their member associations. He requested that the letter, which was attached to his report, be made a part of the record.

He indicated that the National Advisory Committee was continuing its efforts to obtain full joint industry adoption of the principles of cooperation established through its many meetings during the past several years. The Committee expected to meet again in New York on September 6,

1968. Mr. Anderson requested that the Joint Industry Advisory Committee be continued. The report was received by the Subcommittee, and the letter of the United Savings & Loan League, dated June 14, 1968, made a part of the record.

The Chairman pointed out that it was not possible to make a change in the Proceedings (1968 Volume I) but that the minutes of this meeting would indicate the error in such Proceedings.

There being no further business before the Subcommittee, the meeting adjourned at 9:30 A.M.

Hon. Richard E. Stewart, Chm., N. Y. by W. C. G.; Hon. James L. Bentley, Ga. by Emory Lipscomb; Hon. Frank M. Hogerty, Jr., Me.; Hon. Donald Knowlton, N. H.; Hon. Eugene P. Brown, Ohio; Hon. Robert D. Haase, Wis.

Joint Industry Advisory Committee to Study Mortgage Industry Problems

Report to the National Association of Insurance Commissioners meeting, June 17, 1968, at Portland, Oregon

Gentlemen:

My name is William M. Anderson. I am Assistant Executive Secretary of the National Association of Insurance Agents and I am speaking today for the Joint Industry Advisory Committee as its vice chairman in the absence of Mr. John P. Burke, Jr., chairman.

In reviewing the proceedings of the Regular Meeting of the National Association of Insurance Commissioners at Honolulu in December, 1967, our committee has discovered an error with respect to a report of joint action taken by the Texas Mortgage Bankers Association and the Texas Association of Insurance Agents. The report concerned adoption by these two Texas organizations of a "Statement of Recommended Practices of the Mortgage Lending and Insurance Businesses."

As entered, page 274 of Volume I of these proceedings (ref: 1968 Proc. Vol. I p. 274) indicates that all of those national organizations which comprise the Joint Industry Advisory Committee to Study Mortgage Industry Problems participated in the development of the recorded Statement. While the National advisory committee commends the Texas organizations for their action to endorse mutually agreed practices, we must point out their Statement is not identical to that which our committee developed, and that the national organizations credited should not be shown as having participated in the development of the Texas document. The committee requests, therefore, that the record be corrected accordingly.

As previously reported, the several organizations represented on the national committee have been engaged in obtaining endorsement and local implementation of the principles contained in the Statement. We are pleased to report this effort is meeting considerable success with both national and local insurance producer, insurance company and mortgage lending groups. On June 14, the U. S. Savings and Loan League advised that a major additional plateau has now been reached. Their letter is attached to this report.

We respectfully request that this letter be entered in the record of this meeting.

The National Advisory Committee is continuing its efforts to obtain full joint industry adoption of the principles of cooperation established through its many meetings during the past several years. We feel this activity has had, and will continue to have, substantial benefit to both industries. To that end, we expect to meet again in New York on September 6 with an agenda which includes initial study of additional proposals and problems involving the relationship of our two industries. We therefore respectfully request that this Joint Industry Advisory Committee be continued.

William M. Anderson  
Vice Chairman

UNITED STATES SAVINGS AND LOAN LEAGUE  
EXECUTIVE COMMITTEE

Executive Offices 221 North LaSalle Street

Chicago, Illinois 60601

June 14, 1968

National Association of Insurance Commissioners  
730 Lee Street  
Des Plaines, Illinois 60016

Gentlemen:

We are glad to report that the Statement of Recommended Insurance Practices of the Mortgage Lending and Insurance Businesses has been adopted by the various state savings and loan leagues, and the great majority of them already have implemented the statement among their member associations as an effective means of settling insurance problems which jointly involve the insurance industry and the savings and loan business.

In most instances the Statement was adopted in the same form as the final draft previously submitted to the National Association of Insurance Commissioners. Such amendments as were adopted in a few states were of a minor nature reflecting local conditions, without changing the basic purpose or intent of the Statement.

Through its Insurance Committee, the United States Savings and Loan League will continue to cooperate with the various state savings and loan leagues in urging their members to obtain maximum benefits from the Statement of Recommended Insurance Practices by fostering adherence to these guidelines.

Respectfully submitted,

Carl E. Clifton Jr.  
Tom Boynton

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Actuarial (F5) Subcom. Report  
(Mtg. 8)

The Actuarial Subcommittee (F5) met at 9:00 A.M. Monday, June 17, 1968.

The Chairman reviewed the proposals adopted by the Subcommittee in Honolulu on December 4, 1967, and the studies and memoranda on this subject which had been circulated to the Members of the Subcommittee during the past six months. Copies of these studies are attached hereto and made a part hereof. He then asked for discussion of the proposal and these studies.

Mr. Christy Armstrong representing California reported that the largest writer of Workmen's Compensation Insurance in California, other than the State Fund, compiled Schedule "P" on the basis proposed by the Subcommittee recasting its data from previous years on an accident year basis. As a result of this analysis, Mr. Armstrong reported that it was clear that the proposed basis produced a much stronger reserve requirement than the present Schedule "P" and that it would require companies to carry larger minimum reserves especially since the latest accident year included a much greater earned premium than the latest policy year. He also reported that the Fireman's Fund Insurance Group made a partial study of the effects of the basis proposed by the Subcommittee and that this Group also reached the conclusion that the Subcommittee's proposal would produce stronger minimum reserves.

After considerable discussion it was moved, seconded and adopted, with only one dissenting vote, that the two recommendations adopted on December 4, 1967, be reaffirmed, which were as follows:

1. Recommendation to the Property, Casualty and Surety Committee that it recommend to the Blanks Committee consideration of the proposal that Parts 1, 2 and 5 of Schedule "P" be modified so as to make the change to an accident year basis as set forth in the attached memorandum which proposes a minimum of change in the present schedule.
2. Similarly, a recommendation to add a new Part 6 to Schedule "P" in the form attached to the aforesaid memorandum.

Hon. David J. Dykhouse, Chm., Mich. by Robert A. Bailey; Hon. Richard S. L. Roddis, V.Chm., Calif. by Christy P. Armstrong; Hon. John F. Bolton, Jr., Ill. by T. Donald Karnes; Hon. Charles R. Howell, N. J. by W. Harold Bittel; Hon. Richard E. Stewart, N. Y. by Frank Harwayne; Hon. Clay Cotten, Texas by Angus McDonald; Hon. T. Nelson Parker, Va. by John S. Jones; Hon. Robert D. Haase, Wis. by Stanley C. Du Rose.

Proposal to Change Schedule P Gradually From a Policy Year to an Accident Year  
Basis and to Add a New Part 6 to Provide a Comparison  
of Current Reserves with Previous Reserves

(ref: 1968 Proc. VOL. I pp. 277-282)

The assignment made to the NAIC (F5) actuarial subcommittee in December 1965 was: To study whether a uniform method could be developed of determining the accuracy of the loss and loss adjustment reserves on Schedule "P" lines.

Many meetings have been held to study various proposals. In June 1967, an industry committee was appointed to work with us in studying the proposals made last June and included in the minutes of that meeting beginning on page 199 of the NAIC proceedings.

As a result of our discussion and study we concluded that Schedule P should present loss reserves in a manner which facilitates an analysis of their adequacy and that to attain this objective, it should do three things: test the adequacy of the reserves carried in previous annual statements, provide a basis for testing the adequacy of the current reserves and establish a minimum reserve.

The proposed change to an accident year basis will improve the function of Schedule P in testing the adequacy of reserves carried in previous annual statements for the reasons given on page 216 of the NAIC proceedings for June 1967 and repeated below. The attached revisions in Schedule P — Parts 1, 2 and 5 have been drafted to make the change to an accident year basis with a minimum of change in the present schedule.

It should be noted here that while no change is necessary in parts 3 and 4 of Schedule P, and none is recommended by the members of the NAIC (F5) actuarial subcommittee, the industry committee would prefer to reduce the requirements in Parts 3 and 4. No change in Parts 3 and 4 will produce reserve requirements for unallocated claim expense under an accident year basis which will be never less than present requirements under a policy year basis. A few insurers, whose policies all expire on December 31, each year, will continue with the same requirements as before. All other insurers will have higher reserve requirements for unallocated claim expense, the amount of increase depending on what proportion of premiums written during one year are earned in later years. The industry committee would prefer to reduce the requirements in Parts 3 and 4 such that the reserve requirements would be unchanged for an insurer writing only annual policies with effective dates that are evenly distributed throughout the year. Such a change in Parts 3 and 4 would increase the reserve requirements for some insurers and decrease them for others, from the present policy year requirements. The members of the (F5) Subcommittee believe there is a distinct possibility that the present requirements are inadequate and recommend no reduction until evidence is furnished that they are excessive.

The revised Schedule P — Parts 1 through 5 will provide a very effective and convenient test of the adequacy of the reserves carried in previous annual statements. The rearrangement of Part 5 will show directly the adequacy of the reserves carried in the 6 most recent annual statements (4 the first year of transition, then 5, then 6 thereafter). The present format requires considerable hand calculation to obtain the answers that the proposed format furnishes directly.

The minimum reserve established in Schedule P will not be affected substantially by the revision to an accident year basis. If anything, it will become slightly more conservative because the most recent accident year is a complete year whereas the most recent policy year is usually incomplete.

A test of previous reserves is not a sufficient indicator of the condition of current reserves. An insurer whose previous reserves have developed inadequacies always claims that it has taken remedial action. Therefore it is essential to provide a basis of comparing the current reserves with previous reserves in a manner unaffected by changes in premium volume so that it can be determined what remedial action has been taken, and whether the current reserves are more or less adequate than the previous reserves.

The present Schedule P does not provide a comparison of current reserves with previous reserves. We recommend the adoption of the attached Schedule P — Part 6 which makes such a comparison.

The proposed Part 6 was developed by Miss Ruth Salzmann of INA in a paper she presented to the Casualty Actuarial Society in May 1967. It has received wide attention and is acclaimed as a very effective testing device. At any rate it is

the best test of current reserves that has yet been proposed for use in the annual statement. The change to an accident year basis provides the necessary data for this test as Miss Salzmann pointed out in her paper. This is another advantage of the accident year over the policy year.

A note of caution should be sounded. The proposed Part 6 is dealing with estimates. It is not possible to determine what the estimated reserves should be with pinpoint accuracy. Changes in claim settlement practices can produce substantial changes in reserve requirements. As a result, the proposed Part 6 should be viewed as an indicator rather than a measure. If it indicates significant reserve deficiencies, additional information and study would be appropriate.

Some industry representatives are concerned that IRS may use Part 6 to measure excessive reserves. It is possible under some circumstances for accurate reserves to appear to be excessive (or inadequate) when displayed in the format of Part 6. This would be true of any effective test of current reserves. In such cases, additional information should set the matter right. Actually such a concern by industry is testimony to the effectiveness of the proposed Part 6.

Many people would like to see other changes made in Schedule P. But it is the feeling of the subcommittee that the change to an accident year basis and the addition of a test of the current reserves are of such fundamental importance that they should not be clouded by other changes of lesser importance which can be dealt with separately at a different time.

If these two changes in Schedule P can be achieved we believe they will make a significant contribution toward our objective of developing a uniform method of determining the accuracy of the loss and loss expense reserves on Schedule P lines.

The reasons for changing Schedule P from a policy to an accident year basis are as follows:

(1) The loss and loss expense reserves carried in the annual statement are for losses with a date of accident on or before the date of the annual statement. Consequently any test of such reserves made at a later date must segregate losses by date of accident. A segregation of losses by date of policy does not contribute anything but confusion to a test of loss reserves.

(2) The other schedules in the annual statement which test loss reserves, Schedules G and O, segregate losses by year of accident rather than by year of policy. Similarly, the tests of loss reserves used by examiners in their triennial examinations of insurers are made on an accident year basis rather than by date of policy.

(3) Policy year data is no longer used for ratemaking in many areas of insurance where it was once used. The requirement to continue to compile policy year statistics solely for Schedule P results in unnecessary expense.

(4) The latest accident year, where the reserves are largest, is a complete year, and is therefore comparable to previous years. This is not true for the latest policy year. In testing the loss reserves it is an important advantage to have the latest year complete and comparable to previous years.

(5) Each accident year covers only a 12 month period instead of the 24 months or more covered by a policy year. As a result the accident year is more concentrated in one period of time and the unpaid losses are closed sooner after the end of the year.

(6) An accident year is not affected by the length of policy terms — annual, semi-annual, three years, etc. This permits a better comparison between years and between companies without the distortions that such differences create in the policy year data.

(7) The statutory minimum ratios when applied to the latest three accident years produce a more conservative requirement than when applied to the latest 3 policy years because the latest 3 accident years include all of the latest 3 policy years plus the premiums earned during the latest 3 years on policies written in previous years.

1. Change the first 3 columns of Schedule P — Parts 1A, 1B, 1C and Part 2 to read as follows:

Years in which policies were issued	Years in which premiums were earned and losses were incurred	Premiums earned (See notes a and b)
	(1)	(2)
Prior to 1961	Prior to 1968	
1961	Prior to 1968	
1962	Prior to 1968	
1963	Prior to 1968	
1964	Prior to 1968	
1965	Prior to 1968	
	Total first period	
1966	Prior to 1968	
1967	Prior to 1968	
—	1968	
	Total second period	
	Total	

In Part 1C retain "(See note 1)" in column (1) and replace "(See notes a & b)" with "(See note 2)" in column (2).

Delete note (a) in Part 2. Re-letter the remaining notes. Revise relettered note (a) to read as follows: "(a) The earned premiums shown for years prior to 1968 should be unchanged from the amounts shown in the 1967 Schedule P. The earned premiums shown for 1968 and subsequent years should be the same as the amounts shown on page 6, column (4) for the same calendar year."

Eventually, in 1975, the first part of the first column can be deleted.



2. Replace the first column of the "Computation of Reserve for Unpaid Bodily Injury Liability Losses (Sections A, B, and C combined)" and "Computation of Reserve for Unpaid Compensation Losses" with the following:

Years in which policies were issued	Years in which premiums were earned and losses were incurred
1966 1967 —	Prior to 1968 Prior to 1968 1968
<b>Totals</b>	

Eventually, in 1970, the first part of the first column can be deleted.

3. Change Schedule P — Parts 5A, 5B, 5C, and 5D as follows:

Annual Statement for the Year 1968

Policy years	Years in which losses were incurred	RESERVE DATE					Cumulative loss payments as of Dec. 31, Current year
		Dec. 31, 1964	Dec. 31, 1965	Dec. 31, 1966	Dec. 31, 1967	Dec. 31, 1968	
	Prior to 1965						
*1962	1965	XXX					
*1963	1965	XXX					
1964	1965	XXX					
1965	1965	XXX					
	Sub-total	XXX					
*1963	1966	XXX	XXX				
*1964	1966	XXX	XXX				
1965	1966	XXX	XXX				
1966	1966	XXX	XXX				
	Sub-total	XXX	XXX				
*1964	1967	XXX	XXX	XXX			
*1965	1967	XXX	XXX	XXX			
1966	1967	XXX	XXX	XXX			
1967	1967	XXX	XXX	XXX			
	Sub-total	XXX	XXX	XXX			
	1968	XXX	XXX	XXX	XXX		

Annual Statement for the Year 1969

Policy years	Years in which losses were incurred	RESERVE DATE						Cumulative loss payments as of Dec. 31, Current year
		Dec. 31, 1964	Dec. 31, 1965	Dec. 31, 1966	Dec. 31, 1967	Dec. 31, 1968	Dec. 31, 1969	
	Prior to 1965							
*1962	1965	XXX						
*1963	1965	XXX						
1964	1965	XXX						
1965	1965	XXX						
	Sub-total	XXX						
*1963	1966	XXX	XXX					
*1964	1966	XXX	XXX					
1965	1966	XXX	XXX					
1966	1966	XXX	XXX					
	Sub-total	XXX	XXX					
*1964	1967	XXX	XXX	XXX				
*1965	1967	XXX	XXX	XXX				
1966	1967	XXX	XXX	XXX				
1967	1967	XXX	XXX	XXX				
	Sub-total	XXX	XXX	XXX				
	1968	XXX	XXX	XXX	XXX			
	Sub-total	XXX	XXX	XXX	XXX			
	1969	XXX	XXX	XXX	XXX	XXX		

\*These lines to be filled in only by companies which charge all losses under policies running for a period of more than one year to the original policy year of issue.

Annual Statement for the Year 1970

Policy years	Years in which losses were incurred	RESERVE DATE						Cumulative loss payments as of Dec. 31, Current year
		Dec. 31, 1965	Dec. 31, 1966	Dec. 31, 1967	Dec. 31, 1968	Dec. 31, 1969	Dec. 31, 1970	
	Prior to 1965							
	1965							
	Sub-total							
*1963	1963	XXX						
*1964	1966	XXX						
1965	1966	XXX						
1966	1966	XXX						
	Sub-total	XXX						
*1964	1967	XXX	XXX					
*1965	1967	XXX	XXX					
1966	1967	XXX	XXX					
1967	1967	XXX	XXX					
	Sub-total	XXX	XXX					
	1968	XXX	XXX	XXX				
	Sub-total	XXX	XXX	XXX				
	1969	XXX	XXX	XXX	XXX			
	Sub-total	XXX	XXX	XXX	XXX			
	1970	XXX	XXX	XXX	XXX	XXX		
	Sub-total	XXX	XXX	XXX	XXX	XXX		

Annual Statement for the Year 1971

Policy years	Years in which losses were incurred	RESERVE DATE						Cumulative loss payments as of Dec. 31, Current year
		Dec. 31, 1966	Dec. 31, 1967	Dec. 31, 1968	Dec. 31, 1969	Dec. 31, 1970	Dec. 31, 1971	
	Prior to 1966							
	1966							
	Sub-total							
*1963	1966	XXX						
*1964	1966	XXX						
1965	1966	XXX						
1966	1966	XXX						
	Sub-total	XXX						
	1967	XXX						
	Sub-total	XXX	XXX					
	1968	XXX	XXX					
	Sub-total	XXX	XXX	XXX				
	1969	XXX	XXX	XXX				
	Sub-total	XXX	XXX	XXX	XXX			
	1970	XXX	XXX	XXX	XXX			
	Sub-total	XXX	XXX	XXX	XXX	XXX		
	1971	XXX	XXX	XXX	XXX	XXX		
	Sub-total	XXX	XXX	XXX	XXX	XXX	XXX	

Annual Statement for the Year 1972

Policy years	Years in which losses were incurred	RESERVE DATE						Cumulative loss payments as of Dec. 31, Current year
		Dec. 31, 1967	Dec. 31, 1968	Dec. 31, 1969	Dec. 31, 1970	Dec. 31, 1971	Dec. 31, 1972	
	Prior to 1967							
	1967							
	Sub-total							
*1964	1967							
*1965	1967							
1966	1967							
1967	1967							
	Sub-total							
	1968	XXX						
	Sub-total	XXX						
	1969	XXX	XXX					
	Sub-total	XXX	XXX					
	1970	XXX	XXX	XXX				
	Sub-total	XXX	XXX	XXX				
	1971	XXX	XXX	XXX	XXX			
	Sub-total	XXX	XXX	XXX	XXX	XXX		
	1972	XXX	XXX	XXX	XXX	XXX		
	Sub-total	XXX	XXX	XXX	XXX	XXX	XXX	

\*These lines to be filled in only by companies which charge all losses under policies running for a period of more than one year to the original policy year of issue.



STATE OF ILLINOIS  
DEPARTMENT OF INSURANCE  
Springfield

January 4, 1968

Honorable Lorne R. Worthington  
Commissioner of Insurance  
State of Iowa, State Capitol  
Des Moines, Iowa 50319

Re: Modernization of Schedule P

Dear Commissioner Worthington:

During the recent Honolulu NAIC meeting, Mr. Richard Baldwin asked me to forward data regarding subject matter, including the action taken in the 1967 session of the Illinois legislature in attempting to meet this pressing problem of adequate claim reserves. Or rather that, at least, some minimum amount, that can be readily computed and measured be ear-marked and set aside for claims. I also believe that it was the concensus of the (D) Committee, of which you are a member, that there be an exchange of information between the various states.

It appears that, except for New York, all the states, all the companies and their trade organizations and the Insurance Accounting and Statistical Association subscribe to an upgrading of Schedule P, with a change to calendar-accident year statistics. This matter has been before the NAIC for many years and a decision is constantly postponed due to the arguments advanced by New York, the basis for which I feel to be non-existent. In addition, no constructive substitute approach is proposed.

Last fall in Fargo, the states of Zone 4 unanimously approved the calendar year method. New York in its most vigorous attack on the proponents of modernization advanced an argument that errors in policy year coding could no longer be detected. Naturally, that is true, as we will have eliminated the basis for making such an error and will have gone to calendar year figures, which are actual statement amounts, with earned premiums being based on general ledger posted writings adjusted by the two computed unearned premium reserves. Tinkering with these figures by a company means altering its fiscal condition.

I am enclosing Xerox copies of certain of our material which discloses the problems we have found with the present Schedule P and the steps we have taken to correct same. We simply found that the present Schedule P does not work, furnishes absolutely no reserve protection to the insuring public as it does not develop meaningful minimum reserves. Our liquidation experience has been that none of our insolvent companies ever had to establish a Schedule P reserve and I believe I can definitely state that we have had more experience in this area than New York. The present Schedule P lends itself to being "plugged" with fictional postings, miscoding and other accounting "high jinks." Thus, in our 1967 legislative session the following program was adopted:

1. Our uniform Schedule P (present NAIC) statutes were repealed.
2. A new statutory provision granted the Director the right to issue a regulation requiring minimum reserves, stipulating how same would be computed. (This is about in line with the new program proposed at the NAIC meeting.)
3. Calendar-accident year statistics were substituted for policy year.
4. "Pure" loss reserves were separated from loss adjustment expenses paid, with separate minimum reserving factors for both categories, that is, a separate "pure" loss reserve and a separate loss adjustment expense reserve computed based on a factor applied to the loss reserve. In this manner we expect to eliminate improper application of paid loss adjustment expenses in reducing the minimum loss reserve requirement.
5. Liability (PD) was added to the (BI) to prevent miscoding. This in both the vehicle and general liability lines of business.
6. Workmen's compensation was covered.
7. The liability portions (both BI and PD) of homeowners, commercial and other multiple peril policies were included by establishing a predetermined percent of the total premium as applicable to these risks.
8. An Illinois supplemental statutory reserve page will be prepared and mailed to all companies with the 1968 annual statement blank.

9. The percentage of earned premiums to be held as a minimum loss reserve will be slightly increased.
10. The minimum loss adjustment expense reserve required will be based on the loss reserve and this should be slightly increased over the present minimum Schedule P requirement.
11. The present Schedule P individual suit reserve amounts will be somewhat increased.
12. Companies will be granted from 3 to 5 years to make the transition and establish the full new reserve amounts.

Sincerely yours,

JOHN F. BOLTON, JR.  
Director of Insurance

By: DONALD KARNES  
Chief Examiner

November 1, 1967

Re: Hearing on Rule 22.01

The minimum claims reserving approach for casualty companies that we are discussing today is not a new invention. For many years there has been a minimum statutory reserve, known as Schedule P and covering liability (BI) and workmen's compensation lines of business. This law required a minimum amount to be set aside for loss reserves, 60% of earned premiums for liability coverages and 65% of earned premiums for compensation. Schedule P was national in scope, as it was included in the uniform annual statement filed by all companies licensed in the United States, with a specific line to report the liability developed on Page 3 of the said statement. This law simply did not work to fully protect the insuring public as various companies nullified the intent of the statute by engaging in the following practices:

1. Miscoding PD paid claims as BI.
2. Loading a great proportion of the home office expenses into the loss adjustment function and then similarly loading the said function costs principally to the BI lines.
3. "Buying back" unpaid losses arising from previously ceded reinsurance or otherwise acquiring loss reserves unrelated to the premiums credited to Schedule P and then applying these losses to reduce the required Schedule P reserves.

Certain companies so thoroughly complicated the Schedule P development, that it became completely impractical, from an examination standpoint, to recast the company figures. Many months of audit work with much acrimonious debate would have been required in unwinding the mass of confusion.

In addition, Schedule P itself was a problem for technicians, difficult to understand, requiring additional statistics with revisions and re-allocations of annual statement figures. A number of years ago both the NAIC and the insurance industry agreed that Schedule P did not meet present day needs, was archaic and required simplification and modernization. Study committees were appointed and as many as three separate NAIC committees have studied the situation. In fact, it has been one of the principal problems discussed at every NAIC meeting. In every meeting I have attended it has appeared that industry has favored various simplifications and the converting from policy year statistics to calendar year premiums and accident year claims. All the states except New York seem to be in agreement as to this new approach and also some substantial increases in the percentages of premiums to be set aside for claims have been suggested. Normally, the suggestions provide for a gradual increase from 60% for liability and from 65% to 70% for compensation.

With all this background, we decided to put Illinois in the forefront of the modernization program, to lead the parade, so to speak, be the first to resast Schedule P, adopt minimums that were meaningful and a statute that would work, could be readily interpreted and could be enforced. Due to the many insolvencies in the high risk automobile business that have plagued our state, Illinois had a special reason to be the leader in implementing and strengthening the present statutory reserve provisions. The converting of policyholders' funds to personal usage through the vehicle of management, agency, adjustment, employment, etc., contracts and thus through these devices siphoning off the funds that should have been held both to pay claims already incurred and/or through the reserve for unearned premiums, held to pay claims that would be incurred during each policyholders duration of coverage, was certainly not a distinctive Illinois problem. Nevertheless, it surely came to its most advanced fruition in Illinois.

Therefore, the theory of the new Illinois supplemental minimum legally required claim reserve was advanced. The original idea envisioned this to be a statutory requirement, with policyholders' monies, both the minimum claims reserve and the unearned premium reserve, granted the nature of fiduciary trust funds to be held inviolate. Management was to be charged with the same care as a guardian of a minor and prohibited, with criminal penalties applicable, from taking policyholders' funds through contract or otherwise.

Both the new Illinois minimum claim reserve, developed through the supplemental schedule, and the unearned premium reserve are of a mathematical computation nature. Judgement factors have been eliminated, the computations have been simplified and are based strictly on statistics and mathematics. Thus, the setting aside of minimum amounts of reserve dollars will have been removed from the realm of estimates and evaluations and placed under the control of accountants. Disputes between case basis claims analysts will be minimized.

The purpose of assuring policyholders a fair share of their premium dollars, that, at least, minimum reserves will be retained and will be available even in cases of liquidation, will be achieved once this program is fully operative. The impairment of these minimum funds should no longer be tolerated in Illinois by our industry and its associations or by the insuring public and their government.

DONALD KARNES  
Chief Examiner

October 26, 1967

Based on the experience and observations of the Department in regard to company solvency, we reach the conclusion that the claim reserve statutes should be modernized in order to give the Director proper authority to correct the situation.

In the last session of the Legislature, the Department therefore introduced S.B. 188, dealing with casualty claim reserves. This Bill was enacted into law. It reads as follows:

"Every such company shall, at all times, maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred, whether reported or unreported, which are unpaid and for which such company may be liable, and to provide for the expenses of adjustment or settlement of such losses and claims. Such reserves shall be computed in accordance with regulations made from time to time by the Director after notice and hearing, upon reasonable consideration of the ascertained experience and the character of such kinds of business for the purpose of adequately protecting the insured and securing the solvency of such company.

"Whenever the loss and loss expense experience of such company shows the reserves, calculated in accordance with such regulations, to be inadequate, the Director may require such company to maintain additional reserves.

"Each company that writes liability or compensation policies shall include in the annual statement required by law, a schedule of its experience thereunder in such form as the Director may prescribe."

The Bill also repeals Sections 379, 381, 382, 383, 384, 385, 386 and 387 of the prior Act.

Based on the authority given to him by this new law, the Director has proposed a regulation and a Supplemental Schedule "P". The proposed regulation and Schedule "P" have the following objectives:

- (1) Substitution of accident year rather than policy year for the bodily injury and workmen's compensation sections.
- (2) Retention of calendar year for the Schedule "P" property damage sections, because it presently appears in pages 6, 8 and 9 in the blanks. However, companies have the option of using accident year schedules for property damage if they so desire.
- (3) Retaining the present method of counting suits.

(4) Setting up minimum statutory reserves as follows :

	Pure Losses	Loss Ad. Exp. Reserve
	Percent to Premiums Earned	Percent of Loss Reserve
	3 Most Recent Accident Years	Total of All Years
Part 1, Sec. A (Auto B.I.)	55%	10%
Sec. B (Other B.I.)	45	15
Sec. C (H.O. etc.)	45	5
Sec. D (Workmen's Comp.)	60	5
	3 Most Recent Accident Years (Calendar or Accident Years)	Total of All Years
Auto Property Damage	55%	10%

The percentages to earned premiums stated above were developed from the consideration of the loss proportion of the premium dollar generally included in rate filings, and the experience developed by the large numbers of companies listed in the "Loss and Expense Ratios compiled from the Insurance Expense Exhibits" published by the New York Insurance Department.

- (5) The minimum average reserve per suit count shown in the NAIC Schedule "P" Part I, column 10 for the fourth most recent policy year should be \$750, and \$1,500 for the fifth, sixth, seventh, and eighth prior policy years. (The use of accident year experience in the proposed Illinois supplemental reports includes one-half of the fourth prior policy year, and this is recognized in the establishment of \$750, instead of \$1,500 for this individual policy year.)
- (6) The minimum average reserve applicable to the suit counts should be considered for the total of each policy year, not for each individual suit count.

I wish to point out that all the information required by the proposed Illinois Supplement to Schedule "P" is instantly available in the present convention blanks. Therefore, the completion of the Illinois Supplement does not require any special tabulations. Further, since the Illinois Supplement needs to be filed only in Illinois by companies doing business in Illinois as a supplement to the standard convention blank, it does not change the convention blank filing requirements for Illinois companies doing business in other states.

To summarize, the proposed Illinois Supplement to Schedule "P" differs from the present NAIC Schedule "P" in the following respects:

- (1) Calendar (accident) year is used instead of policy year.
- (2) It adds the property damage liability for "auto" and "other than auto" to the coverages or lines comprising Schedule "P".
- (3) Pure losses are separated from loss adjustment expense and each is handled separately.
- (4) It changes the percentage to earned premiums used in calculating the minimum reserves for pure loss only. The current NAIC Schedule "P" lumps pure loss and loss adjustment together.
- (5) It establishes a minimum reserve for loss adjustment expense as a percentage of the pure loss.
- (6) It increases the statutory value of each bodily injury suit for the older policy years.
- (7) Workmen's compensation and other liability lines are combined to establish the minimum reserve requirements.

In conclusion . . . I wish to make it clear for the record that the objectives of the new statute and the proposed regulation represent the best thinking of all segments of the Illinois casualty industry. Early in 1966, the Director appointed an Illinois Insurance Advisory Committee, to which he appointed representatives from every phase of the domestic casualty industry, including representation from large and small companies. I particularly wish the record to show that the report of the Advisory Committee's subcommittee on company solvency, dated August 25, 1966, includes among its recommendations the following:

"Statutory provisions pertaining to loss reserves should be amended to strengthen the Department's ability to assure that adequate loss reserves are maintained. Additional study will be necessary to develop specific methods of achieving this aim."

STATE OF MICHIGAN  
DEPARTMENT OF COMMERCE

January 29, 1968

To: Members of the NAIC Actuarial (F5) Subcommittee and Industry Committee

Enclosed is a copy of a letter I sent today to the Chairman of the NAIC Property Casualty and Surety (F) Committee which is self explanatory.

I would appreciate a copy of any comments or material you may send.

Very truly yours,

David J. Dykhouse  
Commissioner of Insurance

jl

Enclosure

cc: Robert G. Espie  
Ruth E. Salzmann  
James F. Gill  
Clyde H. Graves  
Christy P. Armstrong  
Donald Karnes

W. Harold Bittel  
Frank Harwayne  
Angus McDonald  
John S. Jones  
Stanley C. Du Rose

The Honorable Donald Knowlton  
Commissioner of Insurance  
Room 113, State House Annex  
Concord, New Hampshire 03301

Dear Don:

Enclosed are twelve copies of some additional explanatory material on why accident year data is more useful than policy year data for testing the adequacy of loss reserves. This is intended to supplement the rather extensive material attached to the report of the Actuarial (F5) Subcommittee.

This is our response to the understanding reached at the meeting of the NAIC Property, Casualty and Surety Insurance (F) Committee in Honolulu in December, 1967 for additional facts to be submitted to you for distribution to all members of the Committee.

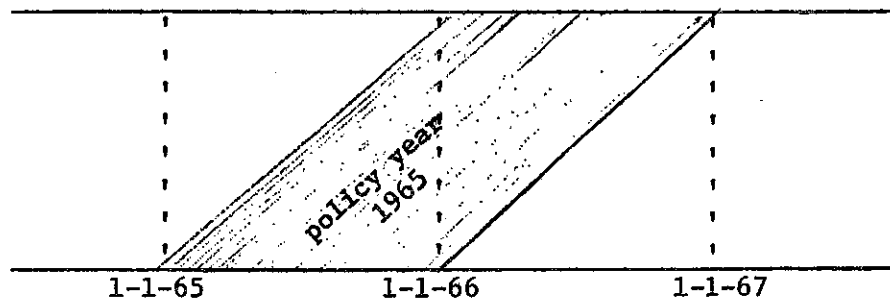
I am distributing copies of this material to the members of the Actuarial (F5) Subcommittee for their review and with a request that they submit any comments or additional material directly to you.

Very truly yours,

David J. Dykhouse  
Commissioner of Insurance

Additional Explanatory Material on Why accident year data is more useful than policy year data for testing the adequacy of loss reserves.

If we assume that the insurance policies are written for a term of one year and their effective dates are spread evenly throughout the year, a policy year can be pictured as follows:

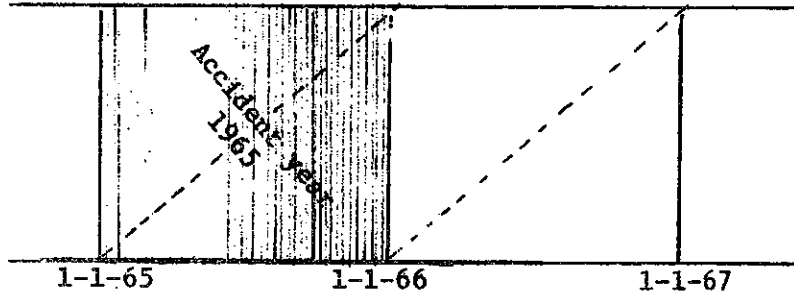




On 1-1-65 only the policies effective that same day contribute to policy year 1965. All the policies effective from 1-2-64 to 12-31-64 are still in force and are contributing to policy year 1964. Gradually as the year 1965 progresses, a higher percentage of the policies in force are in policy year 1965 until the end of 1965 when all the policies in force are in policy year 1965. Then as 1966 progresses a declining proportion of the policies in force are in policy year 1965 until the end of 1966 when none of the policies in force are in policy year 1965.

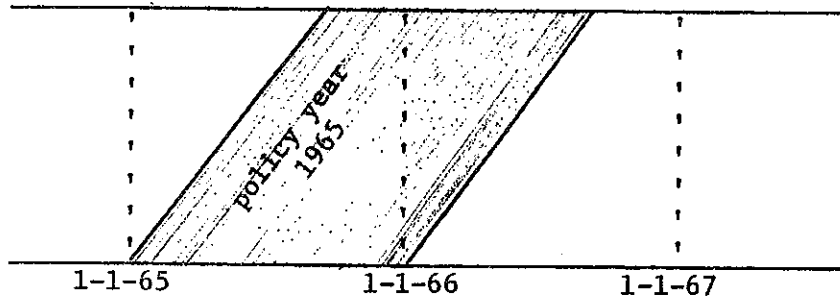
Policy year 1965 is spread over 2 calendar years, covering a triangle in each year which represents half of each year, for a total of one full year.

An accident year can be pictured as follows:

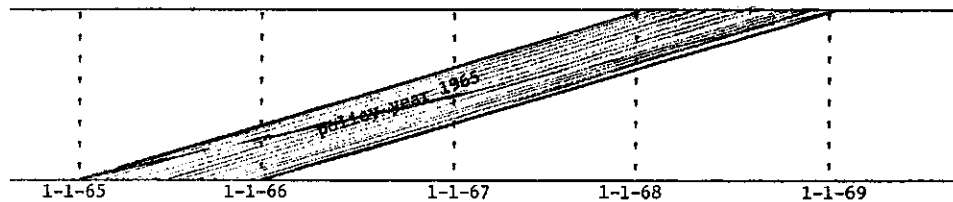


Accident year 1965 includes all the premiums earned and losses incurred in 1965 regardless of the effective date of the policies. From the diagram it can be seen that accident year 1965 is equivalent to the first half of policy year 1965 plus the second half of policy year 1964.

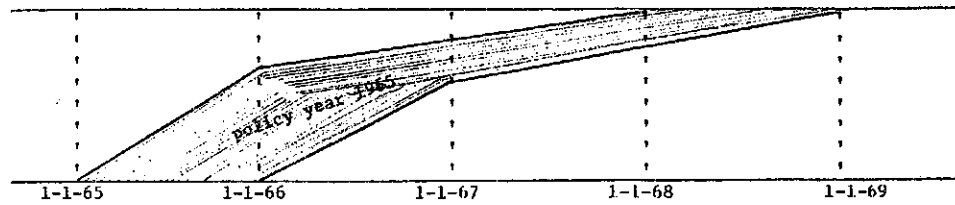
If the insurer writes only 6 month policies, the picture of an accident year doesn't change but the picture of the policy year becomes:



If the insurer writes only 3 year policies, the accident year does not change but the policy year becomes:



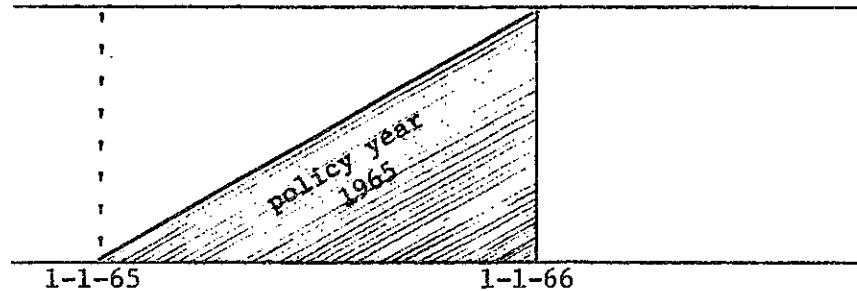
If the insurer writes half of its business in one year policies and half in 3 year policies, the policy year looks like this:



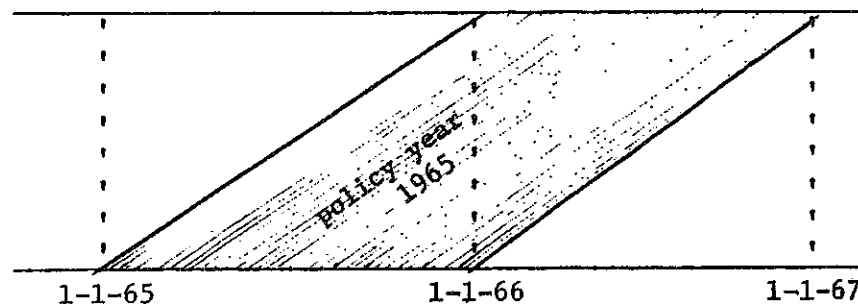
If we try to take into account all the different mixes of 6 month, 1 year, 3 year and other kinds of policies as well as the fact that effective dates are not evenly distributed throughout the year — there are peaks on certain dates such as January 1 — it is easy to see that the policy year has a different shape for virtually every insurer.

How does this affect a test of loss reserves like Schedule P? Three ways:

First, it is difficult to compare a policy year with itself at different stages of development. Schedule P shows the experience separately for each year. The purpose is to permit a comparison of the current report for each year with previous reports for the same years. Any change is intended to indicate loss reserve changes. But such a comparison is meaningful only after a policy year is complete. The policy year itself is changing before it is complete, so that any change cannot be attributed entirely to loss reserve changes. For example, using only annual policies, policy year 1965 looks like this in the 1965 annual statement:



One year later in the 1966 annual statement it looks like:

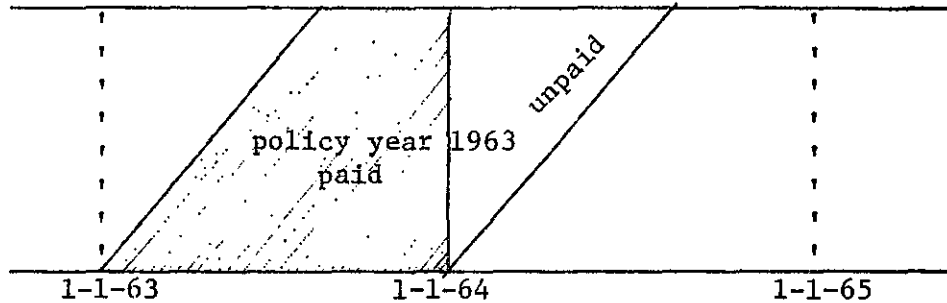


These are not comparable. So we are left with an inadequate test of the loss reserves for the latest policy year, or the latest 3 policy years if 3 year policies are involved.

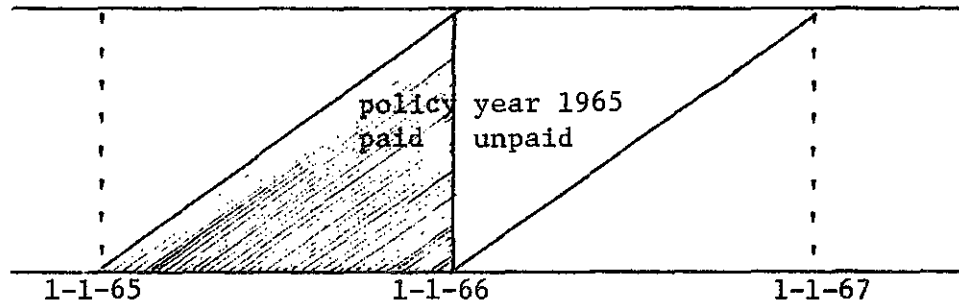
Accident year 1965, on the other hand looks the same every year, so any changes are due entirely to loss reserve changes.

Secondly, if the insurer shifts its mix of 6 month, 3 year or other policies, no valid comparisons can be made of the reserves for different policy years at the same stage of development. For example, if we assume every loss is paid 1 year after its date

of occurrence and if we assume an insurer had been writing semiannual policies until 1964 when it shifted to annual policies, the reserves for policy year 1963 as of 12-31-64 would have been  $\frac{1}{4}$  of the total incurred losses as follows:



and the reserves for policy year 1965 as of 12-31-66 would have increased to  $\frac{1}{2}$  of the total incurred losses as shown below:



If we tried to compare the proportion of losses unpaid in policy year 1965 as of 12-31-66 with the proportion of losses unpaid in policy year 1963 as of 12-31-64, we would get a distorted result because of the shift in the length of the policy terms. This would prevent us from making the type of analysis proposed by the NAIC Actuarial subcommittee as Part 6 of Schedule P, where the reserves for each year are compared at the same stage of development. Accident year data is essential to make Part 6 work and to remove distortions caused by changes in the policy year configuration.

Third, it is impossible to make any comparisons among different insurers of the proportion of reserves in each policy year because of the different configurations of policy years from insurer to insurer. If all were reporting accident year data, we could make more meaningful comparisons.

STATE OF MICHIGAN  
DEPARTMENT OF COMMERCE

February 22, 1968

To: Members of the NAIC Actuarial (F5) Subcommittee and Industry Committee

Enclosed is a copy of a letter I sent today to the Chairman of the NAIC Property Casualty and Surety (F) Committee which is self explanatory.

I would appreciate a copy of any comments or material you may send.

Very truly yours,

David J. Dykhouse  
Commissioner of Insurance

ek

Enclosure

cc: Robert G. Espie  
Ruth E. Salzmann  
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W. Harold Bittel  
Frank Harwayne  
Angus McDonald  
John S. Jones  
Stanley C. Du Rose

STATE OF MICHIGAN  
DEPARTMENT OF COMMERCE

February 22, 1968

The Honorable Donald Knowlton  
Commissioner of Insurance  
Room 113, State House Annex  
Concord, New Hampshire 03301

Dear Don:

Enclosed are twelve copies of some additional explanatory material on why accident year data is more useful than policy year data for testing the adequacy of loss reserves. This is intended to supplement the material attached to my letter of January 29, 1968.

This is in further response to the understanding reached at the meeting of the NAIC Property, Casualty and Surety Insurance (F) Committee in Honolulu in December, 1967 for additional facts to be submitted to you for distribution to all members of the Committee.

I am distributing copies of this material to the members of the Actuarial (F5) Subcommittee for their review and with a request that they submit any comments or additional material directly to you.

Very truly yours,

David J. Dykhouse  
Commissioner of Insurance

**Additional Explanatory Material on Why Calendar Accident Year Data is More Useful Than Policy Year Data in Schedule P**

The only possible advantage that policy year data might have over the accident year data is for premium determination. While Schedule P is designed as a test of loss reserves, not of premiums, the premiums are important because they are used in setting the minimum loss reserves. The minimum reserve requirement for the latest 3 years in Schedule P depends on a ratio to premiums—65% for workmen's compensation and 60% for bodily injury liability. Because the minimum reserve requirement is fixed on the basis of a minimum ratio of losses to premiums, the accurate determination of premiums becomes important.

The question is whether policy year is more accurate than the calendar accident year method for measuring premiums and loss ratios.

From our studies we have concluded that the policy year premiums are more accurate only after the policy year has become fully mature which takes at least 2 years and usually 3 or more years. Since the Schedule P minimum is applied only to the latest 3 years, we have found that the calendar accident year method, while not perfect, is at least more accurate and more conservative than the policy year method for the latest 3 years. For the older years, prior to the latest 3 years, the policy year premiums and loss ratios would be more accurate. But at that time the premiums are no longer used for setting the minimum reserves.

The calendar accident year method not only produces more accurate and more conservative premiums and loss ratios for the latest 3 years, it also is less subject to misallocation and manipulation, unintentional and otherwise, because the calendar accident year premiums are used in determining the gain or loss in surplus in the Underwriting and Investment Exhibit of the annual statement and they are also used in determining the federal income taxes. Any effort to increase surplus would increase the minimum reserves in Schedule P if the same premiums are used in both places. As it is now, the premium bases are different, requiring additional record keeping by the insurers, additional auditing and examination work by the regulators, and a loss of the checks and balances we would have if one set of premiums were used throughout the entire annual statement.

To illustrate why calendar accident year premiums are more accurate and more conservative for the latest 3 years we have prepared the following example for workmen's compensation insurance.

If for workmen's compensation insurance we assume: that all policies are annual policies, that their effective dates are evenly distributed throughout the year, that the deposit premium averages 80% of the final standard premium, that the audited additional premium is billed 90 days after the policy expiration date, that the standard premium is \$1,000,000 for each policy year, and that the incurred losses and loss expenses are 60% of the standard premium we would obtain the following results:

<u>Policy Year</u>	<u>Written Premiums</u>	<u>Earned Premiums</u>	<u>Incurred Losses and Loss Expense</u>	<u>Loss Ratio</u>	<u>Excess of Statutory Reserves Over Case Basis</u>
1965	\$1,000,000	\$1,000,000	\$600,000	60.0%	\$50,000
1966	950,000	950,000	600,000	63.2	17,500
1967	800,000	400,000	300,000	75.0	0
Total	2,750,000	2,350,000	1,500,000	63.8	67,500
<b>Calendar Accident Year</b>					
<u>1965</u>	1,000,000	1,000,000	600,000	60.0%	50,000
<u>1966</u>	1,000,000	1,000,000	600,000	60.0	50,000
<u>1967</u>	1,000,000	1,000,000	600,000	60.0	50,000
Total	3,000,000	3,000,000	1,800,000	60.0	150,000

If premium volume is rising at the rate of \$100,000 per year the results would become:

<u>Policy Year</u>	<u>Written Premiums</u>	<u>Earned Premiums</u>	<u>Incurred Losses and Loss Expense</u>	<u>Loss Ratio</u>	<u>Excess of Statu- tory Reserves Over Case Basis</u>
1965	\$1,000,000	\$1,000,000	\$600,000	60.0%	\$50,000
1966	1,045,000	1,045,000	660,000	63.2	19,250
1967	960,000	480,000	360,000	75.0	0
Total	3,005,000	2,525,000	1,620,000	64.2	69,250
<u>Calendar Accident Year</u>					
1965	\$ 975,000	\$ 935,000	\$570,000	61.0%	\$37,750
1966	1,075,000	1,035,000	630,000	60.9	42,750
1967	1,175,000	1,135,000	690,000	60.8	47,750
Total	3,225,000	3,105,000	1,890,000	60.9	128,250

This illustrates that with a level premium volume, the calendar accident year method produces accurate loss ratios while the policy year loss ratios are overstated (and therefore less conservative) for the latest 2 policy years. With rising premium volume both methods overstate the loss ratios, but the calendar accident year method produces a more accurate and more conservative result for the total of the 3 years included in the Schedule P minimum loss ratio requirement.

State of Michigan  
DEPARTMENT OF COMMERCE

June 5, 1968

Mr. Roger Kenney, Insurance Editor  
United States Investor  
286 Congress Street  
Boston, Massachusetts 02210

Dear Mr. Kenney:

Your two articles on Schedule P emphasized the importance of that schedule in testing the adequacy of loss reserves, its function as a brake on rapid and unsound growth in these inflationary times, and the need to expand Schedule P and to make it as conservative as possible in these times of uncertainty.

As chairman of the NAIC subcommittees that proposed changes in Schedule P, I can say that I am in full agreement with the principles you expressed and I believe all other subcommittee members are also. No one is more aware of the need to strengthen the tests of loss reserves than commissioners who deal daily with insolvency problems.

Our proposals are designed to strengthen Schedule P rather than weaken it. The technical and complex nature of the proposed changes (and of Schedule P itself) however, must be fully comprehended before the present deficiencies in Schedule P and the strengthening effects of the proposed changes can be appreciated and understood.

In many of your articles you have displayed an unusual ability to reduce problems, often complex ones, to relatively simple terms. In this way you have rendered an important service to all of us. But there is grave danger with complex problems that the very process of simplifying will obscure crucial points. This I fear has been the result of your articles on Schedule P reform.

There is no inconsistency between the proposals of the laws and legislation subcommittee that may appear to omit Homeowners and Commercial Multiple Peril policies from Schedule P and the actuarial subcommittee's proposals that leave them in. The proposed model legislation has broadened the scope of the minimum reserve requirements to include all lines of insurance. At the same time, it establishes a "minimum minimum" for workmen's compensation, auto (BI) and liability other than auto (BI). The proposed legislation permits the inclusion of more than the "minimum minimum" and the actuarial subcommittee has accordingly included (BI) liability from homeowners and commercial multiple peril.

The thought is that eventually it may be decided best to set up a separate Schedule P for the entire homeowners and commercial multiple peril policies, not just the (BI) liability portions thereof. This would be possible under the proposed legislation, but is not possible under existing legislation. There is also sentiment in many quarters to raise the minimum percentages of 60% and 65% to a more realistic level. Again this is possible under the proposed legislation which sets the 60% and 65% requirements as "minimum minimums" but is not possible under existing legislation.

The present requirement of including only the (BI) portion of homeowners and commercial multiple peril policies without specifying exactly how much of the premium is to be included, permits an irresponsible company to adjust its premium allocation at will and thereby completely circumvent the purpose of the minimum reserve requirement. The same applies in lesser degree to auto (BI), especially for companies that use package rates for (BI) and (PD) or for all auto coverages. The proposed legislation is designed to permit the broadening of Schedule P to include entire lines of business where premiums are more explicitly defined so as to avoid the manipulation of premiums that is presently possible.

The present requirements to segregate premiums on a basis no longer consistent with the way insurance is written nowadays, imposes burdensome accounting requirements on the responsible companies and at the same time opens the door for other companies to manipulate their premium allocations to correspond to their reserving practices. So you can see that both the commissioners and the responsible company managements stand to gain from the proposed changes.

The change to an accident-year basis is also designed to make Schedule P more conservative and to increase its braking effect on unsound expansion. Enclosed are two memorandums on this subject which I circulated to members of the NAIC committees on January 29 and February 22 of this year.

Briefly, the problem is that although the policy year basis is probably more accurate in matching premiums against losses after the 2 or 3 years it takes for all the premiums to come in, the policy year basis is less accurate than the calendar-accident-year basis during those 2 or 3 years, especially for audited lines such as workmen's compensation, general liability and commercial auto. It takes 3 years to get in all the additional premiums on policies where the exposures are audited after the policy expires. For example, a policy written in December of 1965 is not audited until sometime in 1967.

Since Schedule P applies the minimum reserve only against the latest 3 years, it is easy to see that any understatement of the premiums in the first 2 or 3 years, also understates the minimum reserve requirements as long as the policy year is included in the Schedule P minimum formula. The understatement of premiums and reserve requirements is especially noticeable in the latest policy year which for most companies has a noticeably higher loss ratio. The loss ratio declines in subsequent years as the premiums come in, that is, if the loss reserves are adequate. If the loss reserves are not adequate, the understatement of premiums permits the company to understate the reserves without penalty.

The calendar-accident-year basis will about double the amount of earned premium included in the latest year, including a full year's worth of audited additional premiums. This doubles the reserve requirement for the latest year and eliminates virtually all of the understatement of premiums in the latest 3 years. No one claims that the calendar-accident-year basis is perfect, only that it is better than the policy year basis for the latest 3 years for establishing the most conservative reserve basis.

The proposed no change in parts 3 and 4 of Schedule P fits right in with a more conservative reserve requirement. The amount of paid unallocated loss expense charged against the latest 3 years will not change. But the earned premiums will be increased on the calendar-accident-year basis, at least for the latest year. The reserve requirement, which equals 60% or 65% of the earned premiums less the paid losses and paid loss expense, will be increased correspondingly.

The loss expense reserves contemplated by parts 3 and 4 of Schedule P are woefully inadequate because the fixed percentages in parts 3 and 4 reflect conditions of 50 years ago. Everyone knows how court congestion, claim consciousness and inflation have affected loss reserves since 50 years ago. The proposed change to an accident-year basis will introduce a minor but much needed increase in the minimum reserve requirements for loss expense. The proposed model legislation opens the door for possible further changes in keeping with actuarial studies on the subject.

The proposed new part 6 of Schedule P is in keeping with the widely recognized need for more information about every aspect of the loss reserves. It displays data that would be available from the first 5 parts of Schedule P of the current annual statement and compares that data with corresponding data from the 6 preceding annual statements in a manner designed to make any inadequacies in the current reserves painfully obvious. Part 5 does the same thing now to make any inadequacies in previous reserves painfully obvious. The commissioners, each of whom is responsible for checking the condition of about 500 or more casualty insurers, know the time and staff it takes to audit that many annual statements each year for signs of potential trouble. The proposed new part 6 is designed to make that task easier.

Because of the importance of Schedule P in testing the loss reserves, we believe it is important that everyone involved have ample opportunity to study the recommended changes. We are hopeful that these much needed changes which will improve our ability to regulate for solvency will receive the enthusiastic support of all the commissioners and the responsible company managements when the impact of the changes is fully understood.

Very truly yours,

David J. Dykhouse  
Commissioner of Insurance



State of New York  
INSURANCE DEPARTMENT  
123 William Street  
New York 10038

May 24, 1968

Superintendent Stewart has asked me to forward to you the enclosed copy of the position paper of this Department treating with proposed changes in Schedule P of the Fire and Casualty Annual Statement Blank.

The changes in question are presently before the Laws and Legislation (D) and Property, Casualty and Surety Insurance (F) Committees.

kindest regards.

Sincerely,

Assistant Superintendent

STATE OF NEW YORK INSURANCE DEPARTMENT

Memorandum Re: Proposed Changes in Schedule P  
of the Fire and Casualty Annual Statement Blank

This memorandum is submitted in supplementation of views expressed orally in December, 1967 at the Honolulu, Hawaii meeting as representing the position of the New York Insurance Department in respect to proposed changes in Schedule P presently pending consideration before the Laws and Legislation (D) and the Property, Casualty and Surety Insurance (F) Committees.

One of the most important items in financial statements of property insurers

The largest two items on the Liability page of Annual Statements of Property insurers are the Reserves for (a) Unpaid Losses and Loss Expenses and (b) Unearned Premiums. Usually, the largest amounts among the Loss and Loss Expense Reserves are those reported in respect to unpaid Liability\* and Workmen's Compensation claims. The computation of the respective reserves for such losses and loss expenses is shown in Schedule P of the aforementioned Annual Statement Blank.

What is Schedule P?

Schedule P had its origin in a study conducted by the Committee on Reserves other than Life of the then National Convention of Insurance Commissioners (NCIC). Such study was made in 1914 and 1915. Following a hearing held in November, 1915, the Committee recommended at an adjourned meeting of the NCIC held in December of the same year, the adoption of a plan which was the forerunner of the schedule which we have come to know as Schedule P.

Basic principle of schedule

Accounts of events leading up to the adoption of the schedule are not set forth on the pages of history with crystal clarity. However, it would appear to have been the reasoning of the authors that, since unpaid claims on Liability and Workmen's Compensation policies written in the three years immediately preceding the statement date would not have aged to a point whereat it would be possible to establish accurate reserves therefor on an individual case basis, some way had to be found to require insurers to maintain a minimum reserve for such claims during the three-year aging process. Accordingly, the formula approach called for by Schedule P came into being. Such approach employs as its base: (1) Earned Premiums on Liability and Workmen's Compensation policies written in the three years immediately preceding the statement date, (2) Specific factors to be applied to such Earned Premiums and (3) Losses and Loss Expenses paid on such policies written in each of such three years.

The residual amount resulting from the application of the stated factors (fixed

\*Where used throughout this paper, the term "Liability" is intended to relate to Bodily Injury coverage under Liability policies.

at the moment at 60% in the case of Liability business and 65% in respect to Workmen's Compensation business) to Earned Premiums as mentioned, and the deduction, from the indicated product, of Losses and Loss Expenses paid, as in Item 3 above, was to constitute the minimum or "formula" reserve for unpaid Liability and Workmen's Compensation Losses and Loss Expenses on policies written in the years in question.

To those interested in the genesis of the 60% and 65% factors, there is some indication that these amounts were considered to represent the estimated portion of the premium dollar which remains after payment of (1) Costs identified with the production of business, (2) Overhead expenses and (3) Taxes. The difference in respect to Workmen's Compensation business would appear to have been born of the approximate difference between the acquisition cost for such line as compared with that relating to Liability business.

#### Policy year approach used from beginning

From the historical facts at hand, it would appear that the architects of Schedule P were imbued with the need for the adoption of a formula which would avoid calculations which would deduct Loss and Loss Expense data from any unrelated Earned Premium figures. It would appear further that such reasoning impelled them to decide upon what has come to be known as the "Policy Year" principle and which is still found in the current schedule. Such principle contemplates that Earned Premiums will be reported as developments of the year in which the underlying policies had their inception. It contemplates further that all Losses and Loss Expenses incurred on policies written in a particular year shall be charged as developments of that year. Stated briefly, Earned Premiums on policies written in given years and the Losses and Loss Expenses incurred under such policies are treated in a manner which presents them in proper relation to each other.

#### Schedule not perfect

Few will defend current Schedule P as being a model of perfection. Most certainly there are some areas which can and should, perhaps, be improved. One that comes readily to mind is what some regard as the outmoded provision relating to suit factors. However, the schedule seems to have served reasonably well through the years for all its faults, fancied or real.

#### Periodical suggestions for change

From time to time, the statement has been made that the schedule is archaic and that it requires modification to make it an up-to-date instrument for the computation of the Reserves for Unpaid Liability and Workmen's Compensation Losses and Loss Expenses. However, there is no apparent record of any earlier suggestion that there exists any need for drastic and widespread changes such as those submitted for consideration by the Laws and Legislation and the Property, Casualty and Surety Insurance Committees at the December, 1967 meeting of the NAIC held in Honolulu, Hawaii. (Ref: 1968 Proc. Vol. I.)

#### Basic changes currently proposed

The proposals submitted are two-pronged in nature. Stated briefly, the first recommends adoption of a proposed Model Bill, which, in effect, would enact new Schedule P legislation. The second, which suggests certain amendments to Parts 1A, 1B, 1C and 2 of the schedule, is somewhat complementary of the first. Moreover, it also proposes a re-arrangement of Parts 5A, 5B, 5C and 5D of the schedule and the addition of new segments which would be designated as Parts 6A, 6B, 6C and 6D.

#### Additional Change

The comments set forth in the last paragraph appearing on Page 2 of Attachment No. 1 of the December 4, 1967 report of the D1 Sub-Committee would appear to contemplate another significant change. It seems to suggest that the portion of the premiums and loss and loss expense payments on Homeowners and Commercial Multiple Peril policies relating to Liability exposure be excluded from the Schedule P computation in respect to Liability business. The stated comments characterize the currently required inclusion of such data as meaningless. It would be well to note here that it was only a comparatively few years ago that the Committee on Blanks concluded that the items here mentioned are essential to the proper preparation of the Fire and Casualty Annual Statement Blank and approved a special means for the reporting thereof in Schedule P.

#### Stated reasons for proposed changes

Summarized briefly, the stated reasons for the suggested changes are:

- (1) Calendar-accident year approach will produce more efficient results.
- (2) Policy year data no longer used in rate-making.
- (3) Accident year data permits a better comparison between years and between companies.
- (4) Calendar-accident year method would produce a more conservative minimum reserve requirement.

Each of the foregoing will be appropriately treated in the comments which follow in this paper.

#### Effect of the proposed changes

The proposed Schedule P legislation would scrap the time-honored "policy year" principle earlier described in this paper. It would substitute in lieu thereof the "calendar-accident year" method in respect to Earned Premiums and Losses and Loss Expenses of the three years immediately prior to the date of the Annual Statement. Contrary to the procedure called for by the "policy year" approach, the "calendar-accident year" method would require Premiums Earned during a calendar year to be reported as having been earned in such year regardless of when the policies were written. The figures so reported for the aforementioned three years would form the base for the application of the 60% (Liability) and 65% (Workmen's Compensation) factors presently employed in the schedule. From the product of such computation would be deducted the amount paid in each of the said three years for Losses and Loss Expenses incurred in such years.

No longer would the "policy year" principle called for by the present schedule, and which is also prescribed by the Laws of some states, be employed. Instead, the formula reserve for unpaid Liability and Workmen's Compensation Losses and Loss Expenses would be computed on a basis whereunder Loss and Loss Expense payments would be deducted from premiums to which they may have no relation. In a word, the proposed new format, by figuratively comparing apples with oranges, would, in our opinion, run counter to all sound actuarial and statistical principles.

The suggested changes in Parts 1A, 1B, 1C and 2 of the schedule are essentially editorial in nature and would conform such Parts to the proposed changes above described.

The proposed re-arrangement of Parts 5A, 5B, 5C and 5D is primarily designed to provide for a gradual change-over to the "accident year" basis.

The further suggestion that new Parts 6A, 6B, 6C and 6D be added to Schedule P has for its purpose the requiring of additional information, which, the proponents seem to reason, would be more meaningful. The reason advanced for this proposal is that the various schedules comprising Part 5 as presently constituted require considerable "hand calculation" to obtain answers, which it is claimed, the new Parts will furnish directly.

#### No change in Parts 3 and 4

No change is suggested in respect to Parts 3 and 4 of Schedule P. Such Parts treat with the distribution of Unallocated Claim Expenses. At the present time, such distribution is on a strictly policy year basis. It would be devoid of meaning, in our opinion, to add data prepared in such manner to Loss and Loss Expense figures prepared on the "calendar-accident year" basis. Indeed, the mere suggestion that they be used in such fashion would seem to raise a question as to the consistency of position on the part of the proponents. It is significant that, when industry representatives were requested at one point to develop pro-forma Schedule P figures on a calendar-accident year basis comparable to the "policy year" basis, which, as earlier noted, is now called for by the Schedule, they agreed it could not be done because of their inability to obtain Unallocated Claim Expenses by "accident year".

#### Schedule P data never intended to serve rate-making process

In addressing comments to the proposed substitution of the "accident year" basis for the "policy year basis" principle, Attachment No. 2 to the report of the F5 Sub-Committee, dated December 4, 1967, makes the following observation:

“The policy year data is no longer used for ratemaking in many areas of insurance where it was once used. The requirement to continue to compile policy year statistics solely for Schedule P, results in unnecessary expense.”

Such statement, if we interpret the position of the Subcommittee correctly, would seem to place it in the position of urging that Schedule P data should serve the rate-making process. It should be noted here that the Committee on Blanks has repeatedly held that the Annual Statement Blank was never intended to be employed for such purpose.

Proposed new approach offers nothing not now available in Schedule P

As we view the matter, information at the root of virtually every change contemplated by the proposals before the Laws and Legislation and Property, Casualty and Surety Insurance Committees is already contained in the policy year method of reporting called for by the current form of Schedule P. Essentially, the present system requires insurers to furnish both “policy year” as well as “calendar-accident year” figures. The proposed changes would simply eliminate policy year information without substituting anything of demonstrable value in return.

Present schedule provides fine statistical analysis

Each insurance regulatory authority must have information to facilitate detection of both unintentional errors and deliberate efforts to improve the appearance of a financial statement. Present Schedule P provides a ready means of measuring subsequent developments in respect to Liability and Workmen's Compensation claims against the reserves provided therefor at earlier statement dates. Stated briefly, the present schedule calls for the presentation of specific information relating to calendar year events in such manner as to facilitate review by Department personnel. Evaluation of indicated changes in underwriting fortunes of an insurer is also aided by the current system.

Proposed Model Bill not a sound approach

The lack of statistical soundness becomes immediately obvious when it is considered that, under the proposed Model Bill, a lower minimum reserve would result from the deduction from Earned Premiums in the current calendar year of amounts representing retrospective return premiums on policies written in earlier years. Thus would the indicated loss ratios for such earlier years be reported at what, in our opinion, would be an incorrectly reduced amount while, conversely, that for the current calendar year would be artificially inflated. Under the proposed new approach, regulatory authorities would be deprived of several means of verifying data reported in Schedule P. Illustrative of such fact is the proposed omission of Premiums Written from the schedule. The lack of such essential information would preclude verification of important figures appearing in the financial statements of Property insurers.

The proposed new arrangement would also deprive Department personnel of the currently available means of ascertaining loss ratios on Liability and Workmen's Compensation business and the point at which such ratios stabilize. Such information is of invaluable aid, in both the auditing and examining processes in measuring the adequacy of reported Loss and Loss Expense Reserves on the stated classes of business.

Present schedule facilitates detection of errors

We should like to comment here upon a recent review by this Department of the underwriting experience of a large insurer. Such study uncovered a type of situation through analysis of the policy year data shown in Schedule P which, in our opinion, would never have come to light had the proposed calendar-accident year method been in effect. In the case in question, a desk audit of the present Schedule P data enabled Department personnel to uncover a serious error and to make accurate approximations of its magnitude. (It later developed that the error involved \$30 million of written premiums covering a single policy year). We hasten to add that this error, fortunately, did not affect the financial condition of the insurer involved since its case basis reserves were higher than the remainder computed on the formula basis. However, it is cited here to show the possibilities which would exist and may multiply under the calendar-accident year proposal.

The insurer's response to the Department's request for an explanation is self-explanatory and is quoted here for informational purposes:

“On March 1, 1966, some changes were made in our data processing programs for internal reasons and an error was

made in a program which resulted in private passenger automobile business being assigned to incorrect policy years. This error persisted until August, 1966 when it was discovered and the program was corrected. Unfortunately, it was not reported to those who would have appreciated the ramifications of the mistake so the errors caused by the incorrect program were only brought to light by . . . (Department's) letter of November 10, 1967. . . . We estimate that we shall be able to furnish a corrected 1966 Schedule P about February 1, 1968."

As will be apparent, the insurer here involved is a large one with many years of experience in the insurance business and in reporting operating results. It also has a large and competent staff. If, as we have every reason to believe in this case, the error resulted from oversight, yet we must invite attention to the great possibilities which would be available under the calendar-accident year method to an insurer which may deliberately choose to mislead others in respect to its underwriting experience. It is our opinion that, in such a situation, and assuming the proposed new order were in effect, the malefaction would go undetected in a mere desk review and Department personnel would normally be unable to discover the manipulation without a physical examination of the insurer's internal records.

#### Policy year vs. calendar-accident year

Attached for illustrative purposes is Exhibit A-1, which presents a comparison of results under the present policy year system of reporting with those which would result under the proposed calendar-accident year approach. The illustration is patterned after the example set forth in the additional explanatory material prepared by the Michigan Insurance Department under date of February 22, 1968, and purporting to show why calendar-accident year data is more useful than policy year data in Schedule P. Using basically the same data but employing another set of reasonable assumptions, the said Exhibit shows that, quite contrary to the statement made on Page 3 of the said additional material, the policy year method can and will produce the more accurate and more conservative loss and loss expense reserves on policies written in the three years immediately preceding the Annual Statement date than those which would result under the proposed calendar-accident year approach. In point of fact, Miss Ruth E. Salzman, upon whose actuarial views and qualifications the Actuarial Subcommittee appears to have placed great reliance, would seem to share such view. In a paper presented by her at a meeting of the Insurance Accounting and Statistical Association held in Dallas, Texas in May, 1967, Miss Salzman commented as follows: (Ref: 1967 Proc. Vol. II pp. 498-513.)

"There is little question that calendar-accident year ratios are theoretically less accurate than policy year ratios."

The assumptions used in the preparation of the aforementioned Exhibit which differ from those employed by the Michigan Department were that:

- (1) The premium billed in the first year averages 60% of the final standard premium.
- (2) Premium volume is rising at the rate of 25% per annum.
- (3) The entire premium has been fully billed by expiration.

In all other respects, we have used the same assumptions as the Michigan Department. Apropos item 3, it should be noted that most insurers bill the major portion of their premium volume on a deposit premium basis and that such business is audited several times each year (payroll figures submitted by employers and accepted by insurers are regarded as audited figures). The pertinent manual rule contemplates that the full premium will be due some months prior to expiration. The foregoing observations are supported by examination of individual Annual Statements which reveal that there is little, if any, growth of premium in the third year. Notwithstanding, we have also prepared and annex hereto Exhibit A-2 which employs the assumption that the audited additional premium is billed 90 days after the policy expiration date. All other assumptions are identical with those used in the preparation of Exhibit A-1. The former Exhibit demonstrates, and again quite contrary to the contention of the Michigan memorandum of February 22 hereinabove mentioned, that the policy year method can and will produce more accurate and more conservative reserves than the calendar-accident year approach.

Even more important, the Michigan assumption relating to late reporting of deposit premiums must remain arbitrary, since the calendar-accident year method would bury late reportings, under-reportings and retrospective returns in a single calendar year

premium, thereby preventing their detection. Moreover, in evaluating underwriting experience, the Examiner could never be sure whether indicated changes in such experience had been due merely to (a) failure to report premiums, (b) return premiums or (c) an actual change in underwriting.

In contrast to the confusion which we envision would result under the calendar-accident year approach, the present policy year method is self-correcting. It also shows the changes in and shifts of premiums and losses from year to year and between policy years. Examiners are thus able to make a more accurate appraisal of the quality of changes in underwriting. The defect noted by the Committee on Annual Statement of the Casualty Actuarial Society (see 1965 proceedings of the Society - Volume LII, Page 256), to the effect that Earned Premiums are not always determinable with the same timing as the reporting of claims, would never be corrected by calendar-accident year reporting. However, it is always corrected in the reporting of completed policy years.

One of the key assumptions made in the aforementioned Michigan memorandum of February 22 is that deposit premiums average 80% of final standard premiums. On the calendar-accident year basis, any percentage could be assumed and would not be verifiable. Thus could attempts be made by managements to ascribe any extraordinary underwriting results to a possible shift in deposit premiums. On the other hand, the policy year method provides sufficient detail to permit realistic appraisals of the effects of deposit premiums and underwriting results.

Part 5 of schedule already calls for accident year data

We should like to emphasize here that, not only does present Schedule P provide information on a policy year basis, but, in addition, it furnishes, in Part 5 thereof, data on a policy-accident year basis. Thus is it possible to observe the experience on incurred losses on either a calendar-accident year or policy year basis. The proposed new approach would destroy the means now available to inspect experience on a policy year basis and, consequently, would deprive insurance departments of important information useful to examining personnel.

Proposed re-arrangement of Part 5

We stated earlier that the proposed re-arrangement of Parts 5A, 5B, 5C and 5D is designed to provide a gradual change-over to the "accident year" basis. However, the suggested new format would also eliminate certain information called for by the present segments of Part 5 which provide a ready means of reviewing reserve experience.

It is contended by the proponents that the proposed new arrangements will show directly the adequacy of reserves as reported by insurers in their six most recent Annual Statements. In point of fact, the proposal, requiring as it does the reporting of incurred claim costs of all prior years in each column, provides an unsatisfactory basis for checking purposes. The first entry which would be called for in the "Reserve Date" column is the total incurred claim costs of accident years prior to those for which amounts would be individually reported below the stated figure. The individual figures in each case would be added to those relating to the earlier periods thereby providing (1) a sub-total for each individually added accident year and (2) a total for each Reserve Date column.

It is obvious that the totals of the Reserve Date columns would cumulatively develop into very large figures. The magnitude of such figures relating to total incurred costs of all prior years, therefore, dwarfs the relative difference between totals as of various reserve dates, particularly if reserve deficiencies or redundancies in earlier years were to be offset by counter developments in later years.

The present segments of Part 5 provide a ready and reasonably efficient means of measuring the experience on reported loss reserves on Liability and Workmen's Compensation business. The proposal here under discussion, would not only remove the stated means, but would substitute in its stead an approach, which, in our opinion, will neither prove as efficient as the present mode nor will it accomplish the goal claimed for it.

Proposed new Parts 6A, 6B, 6C and 6D

The proposed new additions to Schedule P which would be designated as Parts 6A, 6B, 6C and 6D seem to have been predicated upon a feeling on the part of the proponents that Schedule P as presently constituted does not provide a comparison of current reserves with previous reserves.

Another stated reason for the change here contemplated is that the various schedules comprising present Part 5 require considerable "hand calculation" to obtain an answer,

which, it is claimed, the proposed new Parts will furnish directly. We do not share such view. Facetiously, we are impelled to observe here that this is the first time, within our memory, a seeming work allergy has served as a reason for a suggested change. In a more serious vein, we should like to invite attention to the fact that review of reserve data reported by insurers authorized to transact business in the State of New York has not been so arduous as to deter the Audit Bureau of the New York Insurance Department from analyzing them, in keeping with its custom, and ascertaining that the reserves as reported in the 1966 Annual Statements of 70 Property insurers were deficient in the total amount of over \$117 million. On the basis of such review, and after appropriate communication with management in each case, the necessary adjustments were made in the Annual Statements.

Aside from the foregoing, may it suffice to say that the suggestion here advanced seems to indulge in the hypothesis that the incurred claim cost of each accident year as of the statement date is as near accurate as ascertainable since it reflects the most recent claim developments. On the basis of such theory, the proposed new Parts contemplate the deduction of payments made each year from the developed claim cost as of the statement date. The remainder purports to show what the reserves should have been at each of the five year-ends shown. The proposed new Parts would not furnish a comparison of current reserves with previous reserves since the data in respect to the latter would not be shown.

Wholly aside from their statistical infirmities, there is no showing that the proposed new Parts would either produce meaningful information for various Insurance Departments or that they would provide essential data not already available in figures submitted in respect to the present requirements of Schedule P.

#### Function of Part 5

It is contended by the proponents that the proposed accident year approach will provide a better comparison of reserve data between years and between companies. Not only is there a lack of convincing evidence to support the thesis advanced but, further, and as we have earlier stated, present Parts 5A, 5B, 5C and 5D already reflect information by accident year. Moreover, it is not now nor, to our knowledge, has it ever been the purpose of the various segments of Part 5 of the Schedule to serve as a means of comparing the experience of one company with that of another insurer or insurers. Their sole function has been to (1) show the experience on reported reserves on unpaid Liability and Workmen's Compensation claims and (2) enable insurance regulatory authorities to weigh judgment on the reported financial condition of insurers in the light of the results reflected therein as well as in Schedules (G and O). The Schedules last mentioned reflect similar information in respect to other lines of Property insurance.

Judged by remarks which periodically reach our ears, many insurance company executives, far from joining forces with those who would criticize the alleged inefficiency of the various divisions of Part 5, find them to be a most important and helpful means of keeping in close touch with the reserve structure of their companies in particular relation to unpaid Liability and Workmen's Compensation claims. Indeed, it is our understanding that the Internal Revenue Service of the Federal Government is now and has been, for some time past, employing, with apparent satisfaction, the results reflected by Part 5 in considering the amount of Liability and Workmen's Compensation Loss and Loss Expense Reserves to be allowed for income tax purposes.

#### New York position

The remarks here presented are not intended, nor should they be construed as criticisms of those who sponsored the proposed changes. Not only do we hold each in high esteem for his ability and sincerity of purpose, but we also regard each as a friend.

By the very nature of the regulatory process, differences of opinion concerning various principles and matters are bound to arise from time to time. This is wholesome for Insurance regulation, since such differences, properly considered and fairly weighed, may serve to strengthen the supervisory process through the rejection of proposals found not to be in the best interests of the public or Insurance regulation, or through the adoption of others after appropriate modification thereof to meet shortcomings clearly shown to be present.

We are not wedded either to tradition or to practices simply because they have been in effect for many years. We are, in fact, firm believers in the principle that, if tradition or a given practice is no longer fulfilling its intended purpose, we should part company therewith. But we must emphasize that we are opposed to change for change sake.

It has been the customary position of the New York Insurance Department to

support proposals, which, in our opinion, will result in improved supervision and thus more adequately serve the public interest.

No improvement evident

On the basis of our review of the proposed Model Bill and the suggested changes in Schedule P, we are not convinced, for the reasons more fully hereinabove set forth, that they would provide any improvement in the existing order.

Stated briefly, it is our considered judgment that the proposed changes would make Schedule P a less useful tool in regulation for solvency and would do so at a time when the institution that is State Supervision of Insurance should not relinquish any of the good tools which it possesses.

We, therefore, respectfully recommend that the proposed Model Bill and the suggested changes in Schedule P be rejected.



## Exhibit A-1

Workmen's Compensation Insurance—Schedule P  
Comparison of Policy Year and Calendar-Accident Year Bases

<u>Policy Year</u>	<u>Written Premium</u>	<u>Earned Premium</u>	<u>Losses &amp; Loss Expenses</u>	<u>Loss Ratio</u>	<u>Excess Reserve Over Case Basis</u>
1965	\$1,000,000	\$1,000,000	\$ 600,000	60.0%	\$ 50,000
1966	1,250,000	1,250,000	750,000	60.0%	62,500
1967	937,500	468,750	468,750	100.0%	
<b>TOTAL</b>	<b>\$3,187,500</b>	<b>\$2,718,750</b>	<b>\$1,818,750</b>	<b>66.9%</b>	<b>\$112,500</b>
<u>Calendar-Accident Year</u>					
1965	\$ 920,000	\$ 860,000	\$ 540,000	62.8%	\$19,000
1966	1,150,000	1,075,000	675,000	62.8%	23,750
1967	1,437,500	1,343,750	843,750	62.8%	29,688
<b>TOTAL</b>	<b>\$3,307,500</b>	<b>\$3,278,750</b>	<b>\$2,058,750</b>	<b>62.8%</b>	<b>\$72,488</b>

## ASSUMPTIONS :

1. The deposit premium averages 60% of the final standard premium.
2. The audited additional premium is fully billed by the policy expiration date.
3. Standard premium volume is rising at a rate of 25% per year.
4. The incurred losses and loss expenses are 60% of the standard premiums.

## Exhibit A-2

Workmen's Compensation Insurance—Schedule P  
Comparison of Policy Year and Calendar-Accident Year Basis

<u>Policy Year</u>	<u>Written Premium</u>	<u>Earned Premium</u>	<u>Losses &amp; Loss Expenses</u>	<u>Loss Ratio</u>	<u>Excess Reserve Over Case Basis</u>
1965	\$1,000,000	\$1,000,000	\$ 600,000	60.0%	\$ 50,000
1966	1,125,000	1,125,000	750,000	66.7%	
1967	937,500	468,750	468,750	100.0%	
<b>TOTAL</b>	<b>\$3,062,500</b>	<b>\$2,593,750</b>	<b>\$1,818,750</b>	<b>70.1%</b>	<b>\$ 50,000</b>
<u>Calendar-Accident Year</u>					
1965	\$ 904,000	\$ 844,000	\$ 540,000	64.0%	\$ 8,600
1966	1,130,000	1,055,000	675,000	64.0%	10,750
1967	1,412,500	1,318,750	843,750	64.0%	13,438
<b>TOTAL</b>	<b>\$3,446,500</b>	<b>\$3,217,750</b>	<b>\$2,058,750</b>	<b>64.0%</b>	<b>\$32,788</b>

## ASSUMPTIONS :

1. The deposit premium averages 60% of the final standard premium.
2. The audited additional premium is billed 90 days after the policy expiration date.
3. Standard premium volume is rising at a rate of 25% per year.
4. The incurred losses and loss expenses are 60% of the standard premiums.

State of Michigan  
DEPARTMENT OF COMMERCE

June 7, 1968

To Members of the NAIC D, D1, F and F5 Committees:

On May 24, 1968, Mr. William C. Gould, Assistant Superintendent of the New York Insurance Department, circulated copies of a position paper regarding proposed changes in Schedule P of the Fire and Casualty Annual Statement Blank.

The changes in question are presently before the Laws and Legislation (D) and Property, Casualty and Surety Insurance (F) Committees.

New York's position paper is helpful in focusing attention on the questions and concerns that many people have regarding Schedule P. Schedule P and the whole subject of testing loss reserves are complex and difficult, but important in regulating for solvency. Accordingly it is not surprising that many questions, misunderstandings and differences of opinion have arisen in the course of trying to improve the existing schedule.

Hoping that a discussion of the differences of opinion will help us all come to a fuller understanding of the problems at hand, we have prepared the attached remarks concerning several portions of New York's position paper using, for ease of cross reference, the same headings they used followed by the page number of their paper.

For your information, we are also enclosing copies of 2 papers on the subject of Schedule P presented in May, 1968, at the Annual Convention of the Insurance Accounting and Statistical Association in Minneapolis.

Sincerely yours,

David J. Dykhouse  
Commissioner of Insurance

by

Robert A. Bailey, Director  
Insurance and Actuarial Section

Enclosures

## STATE OF MICHIGAN INSURANCE BUREAU

Comments on New York's Memorandum Regarding Proposed Changes in Schedule P.  
Additional Change (Page 3)

It is incorrect to assume that the subcommittees contemplated the elimination of Homeowners and Commercial Multiple Peril policies from Schedule P. What was eliminated was the requirement to include only the bodily injury liability portion of such policies and thereby to permit the inclusion of entire lines of business. During the transitional period no change was made in the present coverages included in Schedule P to allow time for further studies on precisely what changes should be made and to concentrate at this time on the more important change from a policy year to a calendar accident year basis.

## Effect of the Proposed Changes (Page 3)

The New York Department claims that comparing calendar year earned premiums with accident year incurred losses is like comparing apples with oranges.

We agree that they are not perfectly comparable. We only claim that they are more comparable than policy year earned premiums and policy year incurred losses for the most recent three years.

In both examples that the New York Department furnished in Exhibits A-1 and A-2, the calendar accident year loss ratio for the latest three years is closer than the policy year loss ratio to the true loss ratio. Their examples illustrate what we have been trying to say, that both policy year data and calendar accident year data are imperfect, and if one involves an "apples and oranges" comparison then both do.

In their examples a perfect accounting system would have produced a loss ratio of 60%. Under one set of assumptions they show that for the total of the latest three years, the policy year method produces a loss ratio of 66.9% and the calendar accident method produces 62.8%. Under another set of assumptions they show that the policy year produces 70.1% and the calendar accident year method produces 64.0%. In both cases the calendar accident year method produces a result that is more accurate and also more conservative than the policy year method.

Calendar year earned premiums are very closely related to accident year incurred losses, even though some of the premiums earned in the current calendar year are derived from policies written in previous years. At the end of each year a reserve is established for the unearned portion of all premiums written during the current and previous years. These unearned portions of the policy premiums are carried forward into the next calendar year to be related to the accidents that will be incurred during that year on the same policies. If the method of determining the unearned premiums is accurate then the comparison of calendar year earned premiums with accident year incurred losses will also be accurate.

The method of determining the unearned premiums is considered to be accurate enough so that the surplus is based on it on page 3 of the annual statement. Further, the change in surplus calculated on page 4 of the annual statement is based on calendar year earned premiums and incurred losses.

Inasmuch as calendar year premiums are used to determine the insurer's surplus on the convention statement and are also used by the Internal Revenue Service in determining taxable income, they cannot be said to be unrelated to the corresponding incurred losses or to be an "apples and oranges" comparison.

Since they are used to determine the insurer's surplus and federal income taxes, they are subject to scrutiny by both state insurance department examiners and federal tax examiners. Accordingly the calendar year earned premiums are more reliable and are not subject to as many errors as the policy year premiums. Many of the errors in allocations of premiums to policy years do not affect the calendar year premiums. So there would be no need to have data available to check the accuracy of policy year data. The example of an error in policy year data on page 6 of the New York Department's paper would be entirely irrelevant if calendar year premiums were used.

Calendar year earned premiums must be calculated by each insurer regardless of the requirements of Schedule P. Naturally, if Schedule P requires the insurers to maintain policy year data in addition to calendar year data, the extra detail will involve extra errors. Since Schedule P is the only part of the annual statement which requires policy year data, all of the errors in policy year allocations would be

eliminated if Schedule P is changed to use the same premium basis that the rest of the statement uses.

#### No Change in Parts 3 and 4 (Page 4)

The method of allocation of unallocated claim expense, which is presently done on a policy year basis, is completely arbitrary. For workmen's compensation each calendar year's paid expenses are allocated to the latest four policy years. No expenses are allocated to the years previous to the latest four even though many workmen's compensation claims continue to be adjusted long after the four year period.

A few insurers write all their policies effective on January 1 each year which means that they are on an accident year basis for losses and claim expenses. But the same factors are applied to their unallocated claim expenses as are applied to all other insurers.

To use the same arbitrary factors for accident years is not any more or less devoid of meaning than the present arbitrary factors used for policy years. However, applied to accident years, the same factors are more conservative.

If the New York Department would prefer to change parts 3 and 4 we would welcome their suggestions because we believe a change is in order.

#### Schedule P Data Never Intended to Serve Rate-Making Process. (Page 5)

The New York Department misinterpreted the position of the subcommittee. The subcommittee did not urge that Schedule P data should serve the rate-making process. The subcommittee only pointed out that now in many cases Schedule P is the only reason that policy year data is compiled and that if Schedule P were changed to the same basis as the rest of the statement, the insurers would be able to discontinue compiling policy year data.

#### Proposed New Approach Offers Nothing Not Now Available in Schedule P (Page 5)

The proposed new approach would permit the loss reserves and allocated loss expense reserves for Schedule P lines of business carried in the annual statement at the end of each year for the last eight years to be tested by hindsight. The present approach permits such a test only for loss reserves and only for the latest three years (5 years for those insurers that do not charge all losses under policies running for a period of more than one year to the original policy year of issue).

The proposed new approach also makes available paid losses and paid loss expenses for each of the latest eight accident years. The present approach provides such data only for losses and only for the latest three (or five) accident years. The projection of payments is an important method of testing the current reserves and consequently the additional data available in the new approach is an important advance.

#### Present Schedule Provides Fine Statistical Analysis (Page 5)

The present schedule is helpful in testing loss reserves and we use it because it is all that we have. But it is far from adequate.

Every well managed insurer tests its own loss reserves because accurate reserves are necessary for an insurer to make meaningful decisions in underwriting and rate-making. Even though the insurers go through all the work required to complete Schedule P for their own company, virtually no insurer uses Schedule P to test its own reserves. They all use other methods. The fact that the insurers universally use other methods than Schedule P to test their own reserves even though they have Schedule P available is ample testimony to the inadequacy of Schedule P.

The Casualty Actuarial Society's Committee on the Annual Statement cited three areas of the Annual Statement thought to be the most vulnerable, Schedule P, Categories of Business and Reinsurance. These areas were considered "vulnerable only to the extent

- (a) a conservative objective is not being achieved,
- (b) money is being wasted assembling less meaningful information, and
- (c) meaningful information is being obscured."

In view of the criticisms of Schedule P by persons knowledgeable in the theory and practices of testing loss reserves and in view of the virtually universal use of other methods by the insurers themselves, we are surprised that anyone attempts to maintain

that Schedule P in its present form provides adequate statistical analysis of loss reserves.

Proposed Model Bill Not A Sound Approach (Page 5)

The New York Department incorrectly implies that retrospective return premiums exceed retrospective additional premiums and other additional premiums and that consequently calendar accident year loss ratios would be artificially inflated for the latest year and artificially reduced for the earlier years.

In the first place, the earned premiums for any given calendar year would be taken from page 6 of the annual statement and, once determined, would not change. So it is impossible for the earned premiums for any calendar year to be too low at one reporting date and too high at another reporting date. They would remain the same at all reporting dates.

Secondly, a look at the filed annual statements will show that in most cases the policy year earned premiums are understated at first reporting and increase with each subsequent reporting.

To illustrate the effect this understatement of earned premiums has on policy year loss ratios, the loss ratios for policy year 1965 were calculated for three large workmen's compensation insurers using the incurred losses reported in 1967 and the earned premiums reported in 1965, 1966 and 1967:

Policy Year 1965 Loss and Loss Expense Ratio  
Losses valued as of 12-31-67, Premiums reported as of:

	<u>1965</u>	<u>1966</u>	<u>1967</u>
Liberty Mutual	77%	71%	69%
Aetna C & S	92	77	74
Employers Mutual	81	70	68

The reduction in loss ratio was due to premium increases. The accident year method would have more correctly stated the premiums and would therefore have produced a more conservative minimum reserve requirement.

New York's criticisms of calendar year loss ratios actually are more appropriate as criticisms of policy year loss ratios which indeed are artificially inflated at the first reporting and decline with subsequent reportings.

Proposed Rearrangement of Part 5 (Page 9)

The New York Department has apparently misinterpreted the proposed rearrangement. Both the individual years and the new subtotals will be shown, so that all of the present data will be continued except for the policy year subdivisions of each accident year. The subtotals will be additional data and will provide a direct means of obtaining the total deficiency or redundancy in the reserves reported in the previous annual statements.

Proposed New Parts 6A, 6B, 6C and 6D (Page 9)

Part 6 uses a technique variously known as "rate of settlement" or "projection of payments" to compare the current reserves with previous reserve levels as re-established by hindsight.

Part 6 uses data that would be available entirely from the proposed Parts 1-5 of the latest seven annual statements but which is not available from Parts 1-5 in their present form. It could be compiled by each insurance department from the latest seven annual statements for each insurer instead of requiring the insurers to complete Part 6.

New York is one of the few insurance departments that is staffed with sufficient auditors to thoroughly audit every annual statement. We can understand why they may not be as concerned about labor saving devices. Michigan, we are frank to admit, and probably many other states are not adequately staffed with auditors to prepare a loss reserve analysis for each insurer in as sophisticated manner as the proposed Part 6 and to do all the other auditing we would like to do. We accordingly confess that we are indeed interested in ways to get meaningful information as efficiently as possible. The proposed Part 6 is designed for that purpose.

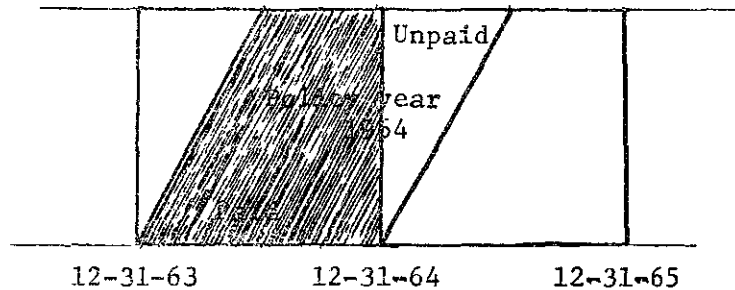
Function of Part 5 (Page 10)

Part 5 is the only part of Schedule P that shows accident year data. That is why it is so useful and important in checking on loss reserves.

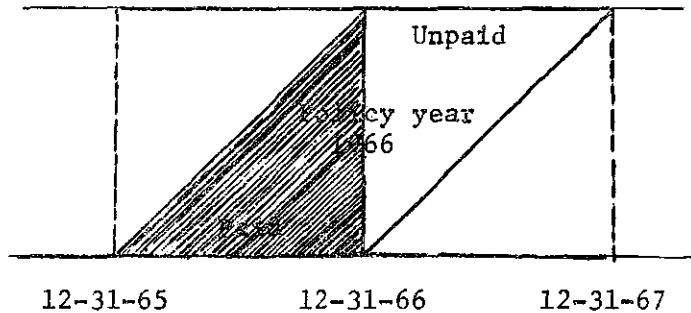
The accident year approach throughout all of Schedule P will provide a better comparison of reserve data between years and between companies. The policy year approach makes such comparisons impossible.

For example, suppose we wanted to compare the reserves for policy year 1966 in the 1967 annual statement with policy year 1965 in the 1966 statement and with policy year 1964 in the 1965 statement and so on back as far as we wanted.

If we assume for the sake of illustration that every loss is paid one year after its date of occurrence and if we also assume the insurer wrote 6 months policies until 1965 and then switched to annual policies, the reserves for policy year 1964 in the 1965 annual statement would have been  $\frac{1}{4}$  of the total incurred losses. The policy year would have looked like this:



But with a switch to annual policies the reserves for policy year 1966 in the 1967 annual statement would be  $\frac{1}{2}$  of the total incurred losses. The picture would look like this:



This shows how any change in the length of policy terms or any change in the distribution of effective dates throughout the year would make comparisons of different policy years meaningless. The same applies for comparisons of the same policy year for different insurers.

Because the accident year is unaffected by the length of policy terms or by the distribution of effective dates throughout the year, valid comparisons are possible with previous accident years at the same stage of development and with other insurers. The NAIC actuarial subcommittee has capitalized on this advantage of accident year data and has proposed a new Part 6 for Schedule P which tests the adequacy of the current reserves by comparing them with previous reserves as reestablished by hindsight.

**Summary**

The fact that the insurers themselves do not use Schedule P to test their own loss reserves but instead use methods of their own is ample evidence (1) that the present Schedule P is inadequate, and (2) that improvements are feasible. The industry has learned much about testing loss reserves in the 50 years since Schedule P was written into the laws of many states. Of the many improvements that have been proposed at various times the most fundamental and important one is the proposed switch from a policy year to a calendar accident year basis. We urge that the NAIC strengthen Schedule P with this much needed and long overdue change so that the insurance departments will be able to keep abreast of and use the advancements that have been made in the past 50 years in loss reserve analysis.

Session Number 459  
 Schedule P  
 Tuesday, May 28, 1968  
 2:30-4:30 P. M.

Current Proposals for Changes In Schedule P

F. Lee Herman

State Farm Mutual Automobile Insurance Company  
 Insurance Accounting and Statistical Association

"Current Proposals for Changes in Schedule P"

Perhaps we cannot solve at this session all the problems nor answer all the questions that have arisen in connection with Schedule P and the related loss reserve activities, but I hope that through our presentation and your questions we can add to your understanding of the problems and to your appreciation for some of the points involved in suggested remedies.

We can reasonably expect that some action on this subject will be forthcoming from the NAIC meeting next month (June 17 through 21, Portland, Oregon).

Whenever we mention Schedule P in a group containing representatives from the various professional and vocational sections of our current insurance society, we expose ourselves immediately to the possibility of becoming involved in an upheaval not unlike the crater of an erupting volcano.

If we were to carry on a discussion about a radio or a television receiver with a native of a locale where such equipment was unknown, we very likely would start with a name, or identification, and a description of the object. After that much introduction, we would almost be forced to acknowledge the purpose of the receiver. From this point we, hopefully, would searchingly feel our way through our mutual vocabulary to discuss the merits of various alternatives of selection to the conclusion that one piece of equipment was best suited for a particular purpose.

Now it seems logical that, within a field of reasonably intelligent people, as we like to think we are, we could name an object, Schedule P, and describe that object by mentioning the various columns, lines, titles and headings and telling how the figures were inserted, arranged and manipulated to the final result.

But when we begin to acknowledge the purpose of Schedule P we find that we are a part of that figurative volcanic upheaval.

An investigation of the purpose(s) of Schedule P takes us back over much history.

For those of you who may want the benefits of a short historical review dealing with the reserves for unpaid Bodily Injury Liability and Workmen's Compensation losses as they were affected by Schedule P, I refer you to a summary of historical background presented by Mr. Frank Harwayne, Chief Casualty Actuary of the New York Insurance Department, November 29, 1965 at a meeting of the NAIC (D2), previously (H2) Subcommittee To Prepare Model Legislation to Modify Schedule P. This summary was reproduced in the 1966 Proceedings of the National Association of Insurance Commissioners. Volume I, page 121 and, for your convenience, is attached to this prepared presentation. (See Exhibit I Ref: 1966 Proc. Vol. I pp. 121-124.)

For the student, the summary contains references to early NAIC Proceedings and those of the Casualty Actuarial Society (as far back as 1902 and 1915, respectively).

From this historical review, Mr. Harwayne cites " . . . there is good reason to conclude

- (a) Schedule P loss reserves for the more recent years of experience was conceived as an expected loss ratio percentage to earned premium from which was deducted actual loss payments ("remaindering")
- (b) Schedule P loss reserves for the earlier years of experience was conceived as the individual company's actual loss reserve on unsettled cases, and

- (c) Schedule P was conceived to place minimum limit on (a) and (b) such that the loss reserves per case would never be less than specifically designated amounts believed to be representative for particular years according to maturity."

In (c) the conclusion to place minimum limits on the reserves for all years implies that the introduction of Schedule P statutes was to serve the purpose of establishing a floor for the liability reserve levels in an effort to lessen any gross under-reserving.

Roger Kenney\*, in referring to the portion of Schedule P then designated as Parts 5 and 5A. said, "It is the scorecard, so to speak, by which a company measures its year-end estimate of Liability and Workmen's Compensation losses incurred on policies sold during each policy year against subsequent developments on those same policies".

Note here the "purpose" was described as measuring past reserves against subsequent development.

Mr. Bailey's proposals to modify Schedule P have been interpreted as being based on the assumption that the primary objectives of Schedule P are

- (a) To test past loss reserves;
- (b) to provide a basis for testing the current reserves;
- (c) to establish minimum reserves.

Here we should draw attention to the emphasis on (b) as a current reserve test. Mr. Bailey's proposals, at least by implication, are being advanced as a test of insolvency.

Representing differently slanted views, within the industry it has been stated that "the Annual Statement and related reports only measure past results, and, unfortunately, these are not reliable indicators of a company's current or prospective status".

At another point I collected an opinion expressed in relation to fixing decision criteria or principles against which to measure any proposed changes in the Annual Statement. This opinion was stated thus:

"The primary purpose of the Annual Statement is to set forth the principal financial data of a company and not to provide data in auditing detail for judging the solvency of a company".

The Casualty Actuarial Society's Committee on the Annual Statement cited\*\* three areas of the Annual Statement thought to be the most vulnerable, Schedule P, Categories of Business and Reinsurance. These areas were considered "vulnerable only to the extent

- (a) a conservative objective is not being achieved,
- (b) money is being wasted assembling less meaningful information, and
- (c) meaningful information is being obscured".

The report goes on to state, "One obvious purpose of the Annual Statement is to test, or to assist in the testing of an insurer's financial ability to meet all obligations arising out of an insurance contract.

"The theory implicit in Schedule P (Parts 1 and 2) is that of setting an arbitrary minimum value on third-party loss valuation until sufficient time has elapsed to remove most of the uncertainty surrounding these valuations. It was never expected that this Schedule could guarantee that a company was reserved adequately if its rates were too low or its claim handling too inept. It was expected that Schedule P (Parts 1 and 2) could prevent a company from dissipating imaginary earnings before someone discovered such earnings were imaginary. This limited objective is entirely compatible with the principle of conservatism.

"The entire Schedule P adds measurably to the recording and preparation expense without contributing material of equivalent value, and without achieving the purpose for which it was intended."

\*"Fundamentals of Fire and Casualty Insurance Strength" - Roger Kenney.

\*\*Report at C. A. S. meeting November 15, 1965.



Obviously, there is not a uniform understanding or agreement regarding the accepted purpose of Schedule P. Or, more likely, new concepts have evolved as to what purposes this historically important schedule can be made to serve.

We may be severely handicapped to reach a firm, uniform conclusion about revising Schedule P if we do not start with an agreed purpose that the document is to serve.

Without pre-determining absolutely a single purpose or describing rigorously within restrictive limits several purposes of Schedule P, we can attempt, nevertheless, to discuss and evaluate some of the suggested changes that have been offered and are under current consideration.

As a first tentative solution we can do away with Schedule P. More than once this view has been advanced although the reasons may have varied. Before this type of action would become feasible it seems to me that some method of answering the questions posed legitimately and/or erroneously by those people now looking at Schedule P must be advanced. Time at this session will limit the depth to which we can explore this possibility. In my opinion a change of this magnitude would be quite revolutionary and might not, necessarily, end up to be a part of the Annual Statement.

At the NAIC meeting of the (H2), subsequently (D2) Subcommittee To Prepare Model Legislation to Modify Schedule P in April, 1964, Mr. Harwayne presented some thoughts regarding proposed changes in Schedule P. Among the elements to be considered were:

1. The need for tracing loss development and the run-off of losses.
2. Kinds of insurance or principal package forms of coverage.
3. Policy year vs. calendar/accident year method of reporting.
4. Minimum provisions for loss and loss adjustment expense.
5. Loss adjustment expenses, allocated and unallocated.
6. Suits.

At that meeting the Subcommittee members agreed that new legislation should be attempted as a replacement for and improvement over the present Schedule P statutes, taking into account the changing needs of the insurance business. The new legislation was to be drafted to include adequate procedures as guidelines for, specifically, achieving the objective of providing reasonable and conservative reserves for losses and loss expense.

Since June, 1964, when the Subcommittee to Modify Schedule P made its report, numerous meetings have been held. A new Actuarial Subcommittee was appointed "to study whether a uniform method could be developed of determining the accuracy of the loss and loss adjustment expense reserves on Schedule P lines".

To jump all the interim developments, the official status after the December, 1967 NAIC meeting can be summarized thus: (1968 Proc. Vol. I, pp. 110-115; 224-226; 275-282)

1. The Actuarial Subcommittee recommended that the Property, Casualty and Surety Committee in turn recommend to the Blanks Committee that Parts 1, 2 and 5 of Schedule P be changed to accident year and that a Part 6 be added.
2. The Property, Casualty and Surety Committee received the report and approved continuing the item for consideration at the June, 1968 meeting with the understanding that the proponents and opponents would attempt to resolve their differences. Further study was to be made by the Committee in the interim.
3. The Subcommittee To Prepare Model Legislation to Modify Schedule P presented a revised model bill and recommended its adoption by the Laws and Legislation Committee.
4. The Laws and Legislation Committee voted to defer further consideration of the Subcommittee report until the June, 1968 meeting, after opposition to the report and the proposed model bill was expressed before the Committee.

We will return to the suggested changes and the model bill later.

Now let's examine some points of at least partial agreement and the important areas of disagreement.

If we classify the possibilities or alternatives the following way, we can examine each.

1. Eliminate Schedule P

If this alternative were taken there are two courses of action:

- (a) let any examination of the now Schedule P reserves be carried on outside the confines of the Annual Statement;
- (b) substitute an entirely new approach as a part of the Annual Statement.

2. Retain Schedule P

If we retain Schedule P we have two choices:

- (a) we can continue it as it is;
- (b) we can attempt to seek proper and constructive changes.

If Schedule P were to be continued "as is", there appears to be a considerable faction opposed and who subscribe to the action taken by the Laws and Legislation Committee in December, 1963 in appointing the Subcommittee To Prepare Model Legislation to Modify, Schedule P, "to meet the changing conditions in insurance".

If we eliminate Schedule P, it seems reasonable to offer to approach the evaluation of reserves elsewhere, either as a part of the recognized financial report, "The Annual Statement", or as a separate analysis of a statistical or actuarial nature.

Now if we disregard, or at least temporarily ignore, replacing Schedule P with a different type of analysis, we are face to face with the question, "What changes are appropriate?", and we now must examine and evaluate the changes offered thus far.

Part 5 (of Schedule P):

Everyone seems to be generally agreed that tracing loss developments, including tests for the run-off of previously established reserves, is desirable. Certainly, the present Part 5 of Schedule P does show the loss development through the "current" date of evaluation. It does not reflect adequacy of current reserves nor provide sufficient data for all companies from which to project reserves accurately.

Currently, although some modifications have been advanced, the retention of Part 5 is not a major point of disagreement.

Method of Reporting:

There is almost universal agreement to change the method of reporting from policy year to calendar/accident year. I must admit, however, that the opponents have been rather firm in their conviction.

The principal objection to the calendar/accident year method is the allegation that "losses fail to track with exposures to loss for the same period of time". Such a position assumes that this "disadvantage" more than outweighs the advantages of shifting to an accident year reporting basis.

The following comment appeared in the (F5) Actuarial Subcommittee report at the December 5, 1966 meeting: (ref: 1967 Proc. Vol. I, pp. 201-206)

"An accident year basis has several important advantages over a policy year basis:

- (1) The latest year, where the reserves are largest, is a complete year and is therefore comparable to previous complete years. This is an important advantage for testing the reserves.
- (2) Each year covers only a 12-month period instead of the 24 months or more covered by a policy year. As a result the accident year is more homogeneous and unpaid losses are closed sooner after the end of the year.

- (3) An accident year is not affected by the length of policy terms—annual, semi-annual, 3 years, etc. This permits a better comparison between companies without the distortions that such differences create in the policy year data.
- (4) Accident year data is more economical because it is necessary for other purposes. Since policy year data is no longer used for ratemaking in many areas, some insurers compile policy year statistics solely for Schedule P—resulting in added expense and possibly added statistical miscoding.
- (5) The statutory minimum ratios when applied to the latest 3 accident years produce a more conservative requirement than when applied to the latest 3 policy years because the latest 3 accident years include all of the latest 3 policy years plus the premiums earned during the latest 3 years on policies written in previous years. Similarly, the proposed Schedule P—Parts 3 and 4 are more conservative than the existing schedules. The existing schedules do not apportion any unallocated claim expense to the older policy years even though claims for those older policy years are still being adjusted and paid. The proposed Parts 3 and 4 automatically recognize differences among insurers in their business and methods of operation and will apply to new insurers equally as well as to insurers which have been issuing policies 5 years or more.”

There can be little question but that the elimination of policy year from the statistical requirements will save considerable expense without detracting significantly from the effectiveness of the data. Many companies have already shifted to summarizing loss experience by accident year. I cannot help feeling that the calendar/accident year basis will be a more serviceable method of reporting loss developments than the present policy year basis.

#### Minimum Provision for Loss and Loss Adjustment Expenses:

One of the big controversies involves the propriety of setting minimum loss and loss adjustment expense reserves based on earned premiums. Here, opinions vary greatly and each variation honestly expressed certainly must reflect, to some degree, differences in the admitted purpose that Schedule P is understood to serve.

No one can argue against correct and adequate reserves, but to draft a requirement that, while uniform for all companies, adequately supports the loss reserve floor so that no company will be short in its reserve provisions and, likewise, will not produce too much redundancy when loss levels and expense levels among companies vary greatly, pushes us toward that volcanic crater again.

At this point we begin to see the merit of the proposal to make Schedule P a subject of regulation by the State insurance authority rather than by statutory formula. Industry representatives have opposed the concept of a statutorily fixed formula and have favored the approach of a general statutory delegation to the State insurance supervisory authority of the power to promulgate regulations concerning liability and workmen's compensation reserve requirements.

It should become obvious that any uniform requirement will affect companies differently and, therefore, the interpretation of the results of such an application of uniformity must be modified because of differences in loss and expense levels.

#### Kinds of Exposure to be Included:

Another important point of departure in thinking involves the exposures to be considered in the Schedule P type treatment.

One faction wants to shift Schedule P lines to a “direct” basis and consider treating reinsurance assumed and reinsurance ceded as though they were separate lines of business.

There are also some strong feelings that other lines and/or coverages should be added to those reported as Schedule P lines. Additions such as Property Damage

Liability and the various package forms of coverage, including substantial elements of liability, have been proposed.

There are opinions within the industry that coverages involving claims that are disposed of relatively soon after loss occurs need not be included in Schedule P and would add to confusion if they were added because of difference in relative loss and expense level.

**Loss Adjustment Expenses :**

Controversial, too, is the inclusion of loss adjustment expenses. Even though reserves need to be carried for this liability, the present arbitrary procedure of assigning unallocated loss expense to the respective experience period, and the inability to test adequately that portion of the reserve provision, leads to the premise that the separation of adjustment expense from Schedule P might lead to better reserve calculation.

Before proceeding further, let's look again at our present status at the national level.

At the meeting December 6, 1967 the (D1), previously (D2) Subcommittee to Prepare Model Legislation to Modify Schedule P presented a model bill to the Laws and Legislation (D) Committee (ref. 1968 Proc. Vol. I, pp. 110-115) (See Exhibit II for text of the proposed bill. (ref. 1968 Proc. Vol. I, p. 115). The bill provided for the option of changing the Schedule from a policy year to a calendar/accident year basis of reporting, retaining the current 65% earned premiums for the most recent three years as a minimum requirement for Workmen's Compensation and 60% for Liability Other Than Auto (B. I.) and Auto Liability (B. I.).

The bill provided for additional coverage to be included in Schedule P by eliminating the reference to ". . . for bodily injury liability and workmen's compensation coverages . . .", with the accompanying comment, "The proposed model legislation avoids this problem (\*that of including allegedly undefined premiums resulting from the new multiple peril lines) by referring to the Annual Statement lines of business and either including or excluding the entire line. No partial lines are included."

This provision brings Property Damage into Schedule P as well as non-liability coverages of the multiple peril lines.

When the report was presented at the meeting of the Laws and Legislation Committee, opposition was expressed, both to the adoption of the Subcommittee report and to the adoption of the proposed model bill.

The action of the Laws and Legislation Committee was that further consideration of the Subcommittee report be deferred until the June, 1968 meeting.

**Now to the Actuarial (F5) Subcommittee—**

This committee was appointed as "a technical committee to study whether a uniform method could be developed of determining the accuracy of the loss and loss adjustment reserves on Schedule P lines".

At the December 5, 1966 meeting the Actuarial Subcommittee made proposals which, among other items, included a recommendation that the basis of reporting losses for Schedule P be changed from policy year to accident year. The proposal was designed for presentation to the Subcommittee by Mr. R. A. Bailey on behalf of the Michigan Insurance Department.

Later, at the December 12, 1967 meeting of the Subcommittee, a paper by Miss Ruth Salzmann\*\* was discussed, in which a method of converting to calendar/accident year basis of reporting was proposed. The paper is a part of the record of that meeting available in the 1967 Proceedings (ref. 1967 Proc. Vol. II, pp. 498-510).

The paper directs attention to three areas of improvements which were referred to as "practical and feasible at the present time".

1. Simplification—Policy year detail was to be eliminated, which was inherent in the proposal made by the Michigan Insurance Department to the Actuarial (F5) Subcommittee for its meeting on December 5, 1966. (ref: 1967 Proc. VOL I, pp. 201-206)

\*Data in parentheses inserted.

\*\*"Schedule P on a Calendar/Accident Year Basis", by Miss Ruth Salzmann; presented to the Casualty Actuarial Society at its May 21-24, 1967 meeting at St. Charles, Illinois.

2. Total Loss Development by Line—A “prior year” line was to be added to Part 5 so that aggregate reserve development will be available.
3. Prospective Evaluation of Liabilities—A new Part 6 was to be introduced in which current loss and loss expense reserves could be compared with reserve levels for prior accident years at the same state of development with these previous reserve levels recalculated to what they should have been at that time in light of subsequent developments.

This Actuarial Subcommittee recommended to the Property, Casualty and Surety Insurance Committee that it (in turn) recommend to the Blanks Committee consideration of the proposal at the March, 1968 meeting that (a) Parts 1, 2 and 5 of Schedule P be modified so as to make the change to an accident year basis and (b) a new Part 6 be added to Schedule P.

The Property, Casualty and Surety Insurance (F) Committee approved continuing this item on the agenda for further consideration at the next meeting with the understanding that the proponents and opponents would correspond in the interim period in an effort to resolve their differences of opinion. Further study by the Committee will be carried on in the interim.

The model bill as submitted is the outgrowth of the following series of “points” that emerged from the Executive session of the (D1) Subcommittee To Prepare Model Legislation to Modify Schedule P held June 12, 1967; (ref. 1967 Proc., VOL. II, pp. 369-372)

- “1. Present Schedule P statutes and reserve formulations are regarded as unsatisfactory.
2. There are numerous, difficult and technical problems involved.
3. There is a need for flexibility in dealing with the problems and in facilitating adaptation to changes in business practices and experience trends.
4. Due to the opposition by industry and to the inclination of many legislatures and regulatory officials to disfavor specific formulations written into the statute law, it is unlikely that a model bill of the specific type such as the Harwayne proposal would in fact be generally adopted.
5. There are several different approaches to the problem of reserve calculations which merit serious consideration, including the Harwayne proposal, but that the development of the best approach or approaches can be better done by the technically competent personnel within the departments and the industry and through the Actuarial Subcommittee (F5) and the Blanks Committee.
6. Any model bill of a type involving a general delegation of power to adopt regulations should apply to all liability and workmen's compensation coverages and not be confined to bodily injury liability. The regulations would be the appropriate place to limit application of reserve formulations or provide for different formulations for different types of liability coverages.
7. Any model bill should continue, as a minimum floor, the present prevailing minimum reserve requirements for bodily injury liability and workmen's compensation.
8. Any bill should confer a broad power on the insurance supervisory authority to require that any insurer establish and maintain greater reserves than those which would result from the formulations expressed in regulations whenever good cause exists to doubt the adequacy of reserves as computed in accordance with the requirements of the regulations.”

Summarizing, to date we appear to be awaiting the next round of action, probably to be forthcoming at the June, 1968 NAIC meeting. Very likely, we are facing some probable changes.

If the calendar/accident year basis is introduced, a gradual change has been suggested in the attachment to the report of the (F5) Actuarial Subcommittee at the December 4, 1967 meeting. (Ref: 1968 Proc., VOL. I, pp. 275-282)

If lines are added, the problems involved will depend on the available information currently maintained by the companies.

Need for additional or supplemental information will be governed by the final NAIC decision and the interpretation and adoption made of the conclusion by the respective states.

Let's turn briefly to the effort made in one state to improve, if not solve, the Schedule P type of reporting problem to offer more understandable data in an attempt to further analyze reserves. I refer to the cooperative action of the personnel of the Illinois State Insurance Department and representatives of the insurance industry. To the best of my present knowledge, the proposal is not final.

Exhibits III, IV and V attached are combined to show the contents of a supplement to Schedule P which is intended, at least in part, to solve some of the problems alluded to throughout this panel. The supplement was initially proposed to apply only to those companies which the Insurance Department felt should report their reserve data in a different form than now given in the present Schedule P of the Annual Statement. However, a proposed regulation has been drafted making the provisions applicable to all Illinois casualty licenses.

This new supplemental form differs from the current Schedule P in the following respects: (In part, from the Ad Hoc Committee report.)

1. The calendar/accident year basis of reporting is used instead of the policy year basis.
2. Property Damage Liability is added for "Auto" and "Other Than Auto" to the coverages or lines comprising Schedule P. Property Damage Liability may be reported on a calendar year basis at the option of the company. The inclusion of the Property Damage coverage in the new form may reduce any misallocation, between Bodily Injury and Property Damage coverages, of the losses and/or premiums.
3. Pure loss is separated from loss adjustment expense and each is handled separately. The separation of pure loss and loss adjustment expense avoids the effect of unusual loading of paid and unpaid loss adjustment expense. This separation highlights the quality of the reserve for pure losses.
4. The last reported compromise on the percentage of earned premium as a minimum support level for incurred losses only (excluding loss adjustment expenses, both allocated and unallocated) is
 

(a) Workmen's Compensation	55%
(b) Auto Liability (B.I) and Auto Liability (P.D.)	50%
(c) Liability Other Than Auto (B.I.), Liability Other Than Auto (P.D.), Liability (B.I.) portion of Homeowners, Multi-Peril and Liability (B.I.) portion of the Commercial Multi-Peril	40%

The statutory value of Bodily Injury suit reserves was established at \$1000 per suit for the 4th prior policy year and \$1200 for the 5th and prior policy years. Policy year for suits was suggested for the periods until accident year data would become available.

5. Loss adjustment expenses were set at percentages of the reserve for liability losses.

Auto Bodily Injury and Property Damage	15%
Workmen's Compensation	10%
Homeowners and Commercial Multi-Peril Bodily Injury Liability	10%
All Other Bodily Injury and Property Damage	20%

These expense percentages are based on actual results of companies' performance.

Additional information about the source material and how the form is completed is contained in the footnotes on Exhibit V. Of particular interest is the Note 1 which explains that all information is available in the present NAIC statement form, although it utilizes the statements from the latest three years.

I refer to this Illinois effort only as an example of the type of activity that we may expect and the type of problem we, as company representatives, are likely to meet and to bring emphasis on the basic problem which, perhaps, needs a more sophisticated solution than any advanced so far.

The people who have worked on the problem of adequate and proper reserves with its effect on solvency and the problem of how and where to present loss data have recognized that partial steps may have to be taken. Such decision does not prevent us from theorizing about a more complete solution.

If we stop to reflect on rate filings, one of the facets deals with the statistics on which rate need is based. Losses are a vital part of the rating data with the reserves for unsettled claims an important section of the computed loss level. Might it not be wise to consider the adequacy of reserves along with the investigations of rate levels where considerably more detail is investigated and where the question of adequacy of rates reflects solvency and proper rate need is a prospective study? We are led to the question of whether we are trying to make Schedule P serve purposes beyond reasonable limits.

Companies do much more calculating, checking and projecting of reserves than we might expect to be included in the Annual Statement. Could we solve our problem better by building a presentation relating exposure to frequency of claims and exhibiting trends in average costs so that projected total loss levels could be evaluated in relation to observed and projected trends? Irregularities would have to be explained just as failure to meet any fair standard regardless of the criteria. Companies collect this sort of data internally, anyway.

We cannot expect to mold every company into one unyielding form.

My principal point here is to suggest caution in the approach to proper reserves and solvency for individual companies through Schedule P.

Some approach along these lines would not be a new idea. The average cost approach is referred to in the laws as far back as 1904, but any consideration of this avenue seems recently to have been pushed into the background. Still, companies are using these techniques.

Don W. Daily's article dealing with average reserves appearing in the February, 1968 "Interpreter" cites the use of average cost per claim pending applied to the number of claims pending in determining end-of-period loss reserves. Tons of material have been written, so we don't lack information and opinions, and it is hard to identify any idea as absolutely new.

We can suggest that if detail on reserves of the degree cited, supplied to show reserve adequacy, were not circulated as widely as the Annual Statement results, but were made available to regulatory authorities, perhaps companies would feel a little freer to make available details considered by some to represent confidential information.

One important point to recognize is that the state regulatory authorities have an important problem. As members of the industry, we need to contribute to the solutions as generously as we can and cooperate in a reasonable and constructive way to the best of our ability with the Insurance Department personnel during the phasing of such

partial and piece-meal evolutions as seem sure to take place. To this end we hope the cooperation between the industry representatives and the Insurance Department personnel in Illinois will prove to be a step in the right direction.

### Exhibit I

#### Annual Statement Schedule P

#### Reserve for Unpaid Bodily Injury Liability and Workmen's Compensation Losses

#### (A Summary of Historical Background)

(Ref: 1966 Proc. VOL. I pp. 121-124)

In order to understand the present basis for Schedule P Loss Reserves, a review of the history and background of Schedule P from its inception to its present form was undertaken.

Based on a study of the literature dealing with Schedule P loss reserves, there is good reason to conclude

(a) Schedule P loss reserves for the more recent years of experience was conceived as an expected loss ratio percentage applied to earned premium from which was deducted actual loss payments ("remaindering")

(b) Schedule P loss reserves for the earlier years of experience was conceived as the individual company's actual loss reserve on unsettled cases

and (c) Schedule P was conceived to place minimum limits on (a) and (b) such that the loss reserves per case would never be less than specifically designated amounts believed to be representative for particular years according to maturity.

In practice, the discovery that some companies had in fact been under-reserving in the extreme prior to Schedule P statutes placed an immediate practical limit on the percentage of earned premium to be used in the loss reserve calculations, hence the Michigan statute at 40%, the later statutes at 50%, followed by increases of 1% each year and culminating in 60% for liability and 65% for workmen's compensation insurance. The informational sources and content are described below.

During the 1890's and the early 1900's, a number of insurers were beset with financial instability. Eventually, the failure of several insurers to make adequate provision for loss reserves came to the notice of insurance departments. Among those directly concerned was the NAIC Committee on Reserves Other Than Life.

Between 1902 and 1916, considerable effort was expended to develop a workable program relating to Schedule P loss reserve requirements. The records remaining may be found in the NAIC proceedings of the era and in the first proceedings of the Casualty Actuarial Society in February, 1915. Volume I of the proceedings of the Casualty Actuarial Society contains a thorough discussion of workmen's compensation and liability claim reserves from pages 90-168. At page 117, Mr. J. H. Woodward, actuary for the New York State Workmen's Compensation Commission indicates the considerations underlying the percentage of earned premiums as follows:

On policies issued or renewed, then, during the two calendar years immediately preceding the date as of which the loss reserve is being computed I suggest that not less than 66 $\frac{2}{3}$  percent of the earned premiums on such policies or renewals, less payments actually made thereunder for losses, be required to be set aside as the loss reserve. The suggested percentage of 66 $\frac{2}{3}$  is arrived at from the consideration that the premiums approved by the Superintendent of Insurance of the State of New York as minimum adequate premiums for workmen's compensation insurance are based upon the assumption that 66 $\frac{2}{3}$  percent thereof is applicable to losses and 33 $\frac{1}{3}$  percent to expenses. Any insurance carrier which conducts its business on an expense ratio of less than 33 $\frac{1}{3}$  percent should be permitted at its option to charge a correspondingly higher reserve.



In this same volume at page 131, Mr. Benedict D. Flynn, Assistant Secretary, Travelers Insurance Company, summarizes the various methods used or proposed up to that time for the calculation of liability and workmen's compensation claim reserves as follows:

The various methods used or proposed in the past for the calculation of Liability and Workmen's Compensation Claim Reserves have fallen under one of the two general headings mentioned below or have been a combination of those two methods. (1) An estimate of the probable cost of outstanding claims—either by means of average claim costs based upon previous experience or by individual estimate. (2) A reserve of that part of the expected loss payments which has not paid out up to date of valuation; that is, the excess of a certain percentage of earned premiums over losses and loss expenses paid prior to date of valuation.

As a basis for determining the most desirable method of reserve valuation let us study the good and bad points of each of these general plans.

The first method bases the claim reserve of a company directly upon the record of outstanding claims, and for this reason, it would appear to be the logical solution of the problem. This method is weak, however, when we attempt to apply it to the great number of immature cases arising from the policies issued in the two years preceding date of valuation—particularly those of Workmen's Compensation contracts. To attempt an individual estimate of these undeveloped claims is a practical impossibility. It is also unreliable even to attempt to throw these cases into certain broad groups by nature of disablement. Even if we grant that such a division could be made upon a reliable basis we are then confronted with the fact that it would be unsafe in the present changing conditions of experience to attempt to fix upon average costs to be used against these broad divisions of outstanding claims by nature of disablement. The weakness of this method as applied to immature cases under Liability policies was shown under the old "notice and suit" method of valuation, first because of inability to obtain a reliable record of the number of notices of accidents received and, second, in the fact that the average notice costs did not follow closely the increased cost resulting from changing conditions. A safe conclusion to make with regard to the first method of valuation outlined above is that it is reliable only when outstanding claims are valued which are of sufficiently long standing to have reached a definite fixed basis. If what might be called immature cases are to be considered, some other method of valuation must be utilized.

The principal advantage of the second method is that it can be applied with results more accurate than under the first method in obtaining the reserve for the immature claims arising from business issued within a few years prior to date of valuation. The value of this method, however, depends first upon a reliable estimate of the proper percentage of earned premiums to be used as the expected loss ratio and, second, upon the assumption that the gross premium basis upon which the business is written by all companies is practically the same. In regard to the first of these two points it should be stated that the plan of using a percentage of premiums based upon the loss ratio under business written from five to ten years previous to date of valuation gives unreliable results. Some percentage which will be a reasonable estimate of the probable ultimate loss ratio for the business under observation should be fixed. In regard to the second point, — that the business of some companies may possibly be written at rates far below the general rate level of other companies, — the method of supervision of rates at present followed in New York and Massachusetts seems to offer a solution so far as Workmen's Compensation

business is concerned. In these states the possibility of some companies writing business at cut rates is practically removed. As the policy of state supervision of Workmen's Compensation rate grows — which will probably be the case — the situation with regard to this feature of the second method outlined above should be gradually improved.

Some of the background for the foregoing quotations may be found in the Proceedings of the NAIC. The 1902 Proceedings documents the need for recognizing that losses on certain lines of insurance are developed over long periods of time. One of the solutions noted is the Michigan statute which required a minimum loss reserve of 40% of the earned premium. Also noted is an alternative suggestion at page 67 that loss reserves be based on pure premium losses and payrolls. As between the two methods, the Proceedings also contain a criticism that the pure premium method would be more burdensome, unwieldy and less appropriate than the loss ratio percentage of premium method.

The record shows quite clearly that the need for agreed upon rules for estimating liability on account of unpaid losses rests in the indeterminate value to be placed on such losses during the early stages following occurrence of a claim. The solution sought through Schedule P was to base the loss reserve amount on that portion of the earned premium which represented expected losses less the loss amounts paid up to the date of valuation.

Scientific and legal advance since the turn of the twentieth century has increased rather than decreased the length of time that the value of a claim remains indeterminate. The court calendars running at a several year lag in many parts of the country serve to increase the indeterminateness of outstanding losses. Coupled with this, is the sophisticated system of premium determination, whereunder calendar year retrospective rating adjustments, premium audits and reinsurance premiums do not necessarily reflect loss exposure during the same period of time, which is not the case where adjustments must be assigned to policy year of issue.

Of particular importance at the present time and touched on by Mr. Flynn is that the business of some companies may possibly be written at rates far below the general rate level of other companies. One recently suggested method of dealing with this problem begins with the understanding that Schedule F deals with rate regulated lines of insurance. The method would permit the percentage of earned premium to fluctuate somewhat in order to give limited recognition of the insurer's loss expectation via its own expenses; this could preserve the simplified loss ratio or percentage of premium approach, while at the same time, it would recognize that individual companies may indeed have differing loss expectations. After the indeterminate period has expired, the loss reserve would continue to be determined on the basis of the individual company's loss estimates and prior historical developments.

The 1912 Proceedings at page 227 gives a history of liability loss reserves. Michigan enacted the first statute on the subject. In 1901 there had been a minimum of 45% of earned premiums. By 1903 this had been raised to 50%. In 1903 the first New York law for liability reserves was enacted as was the first Connecticut law but it was found to be based on wrong premises<sup>1</sup>. In 1904 the second New York law was enacted. It was also enacted with modifications in Massachusetts, Connecticut, Illinois and California. These laws required that the reserve be based on the company's own experience of the final average cost to be applied to the outstanding number of notices and the outstanding number of suits. The minimum standard set up was that the total ultimate cost of claims 18 months prior to the statement date was equal to the company's computed average cost times the number of notices. The minimum reserve was equal to the probable ultimate cost less payments already made. For periods earlier than 18 months prior to the statement date, the reserve was taken to be equal to the number of suits times the average cost of all suits settled during the first five years of the period of 10 years immediately preceding the date of the statement. It was found that there was considerable variance in notices and this created some rather difficult problems with respect to reserving.

The 1906 Proceedings contains the draft of a model law for the District of Columbia prepared by the Executive Committee of the National Board of Casualty and Surety Underwriters. The draft text at pages 47 and 48 contains a provision for a special reserve for losses under liability policies which is based upon past average costs of claims or suits.

<sup>1</sup>The 1904 NAIC Proceedings at page 70 refers to the New York Act of 1903 which proved so unsatisfactory that its repeal was recommended. The New York Law arrived at its reserve by using the average suit and claim cost as derived from each company's experience.

The 1908 Proceedings at page 140 reports that the factor of average cost per settled suit is not large enough in many companies because the average cost is derived from settled suits whereas it is expected that unsettled suits will require a larger outlay than those that have already been settled. It suggests that working with the laws already enacted in New York, Massachusetts, Illinois and California had disclosed even for the short experience period that there was a need for improvement upon those laws.

At page 230 of the 1912 Proceedings of the NAIC reference is made to the laws of 1910-1911 which used the first five years experience of the immediately preceding 10 years modified to include unallocated expenses and amounts of \$750 per outstanding suit, all subject to a minimum loss ratio of 50% for the first year after enactment of the law and rising 1% each year up to 55%. The law also included a basis for "remaindering" so that \$750 per suit was included in the reserves for the first three years and the larger of the actual amount or \$750 per suit, for prior years up to 10 years; \$1000 per suit was used for years prior to the last 10.

The 1914 Proceedings contains a suggestion by the members of the Committee on Blanks of the International Association of Casualty and Surety Underwriters that Schedule O - Part 2 and Schedule P be combined to avoid duplication of information.

In the 1914 Proceedings at page 85 the Committee on Reserves Other Than Life suggests that because of the manner in which rates are being developed, it is probable that the loss reserve for workmen's compensation insurance cannot be based upon the premiums charged for such insurance as contemplated by the loss reserve law. Therefore, an entirely new method of calculating might have to be based upon pure premiums, upon payroll exposure, upon manual or other rates supervised by State insurance departments, or upon some other comparative constant function.

The 1916 Proceedings at page 8 indicates the Committee on Reserves Other Than Life recommended that even though the reserve requirements on workmen's compensation insurance appear to be different from that for liability the compensation reserves of the companies for the year 1915 be made 54% of earned premiums.

At page 164 of the 1916 Proceedings the Committee recommended a proposed law for computing reserves for liability and workmen's compensation insurance, the former to be based on 60% of the earned liability premiums written during the three years immediately preceding the date of the statement, and the latter to be based on 65% of the earned compensation premiums.

The general contents of the proposed 1916 law is recognizably similar to the present statutes with some minor differences regarding the distribution of unallocated claim expenses for companies which have been issuing policies for five years or more.

The 1911, 1912, 1914 and 1916 Annual Reports of the Superintendent of Insurance of New York State of the Legislature further consistently document the history recorded in the Proceedings of the Casualty Actuarial Society and the NAIC.

(Ref: 1966 Proc., VOL. I, pp. 121-124)

#### Exhibit II

##### Model Schedule "P" Bill

(Ref: 1968 Proc., VOL. I, p. 115)

Each insurance company transacting business in this State shall, at all times, maintain reserves in an amount estimated in the aggregate to provide for the payment of all losses and claims incurred, whether reported or unreported, which are unpaid and for which such company may be liable and to provide for the expenses of adjustment or settlement of losses and claims. Such reserves shall be computed in accordance with regulations made from time to time by the (Commissioner, Superintendent, Director), after due notice and hearing, upon reasonable consideration of the ascertained experience and the character of such kinds of business for the purpose of adequately protecting the insured and securing the solvency of such company.

Whenever the loss and loss expense experience of such company shows the reserves, calculated in accordance with such regulations, to be inadequate, the (Commissioner, Superintendent, Director) may require such company to maintain additional reserves.

The minimum reserve requirements prescribed by the (Commissioner, Superintendent, Director) in the regulations promulgated under authority of this section for unpaid losses and loss expenses incurred during each of the most recent three years for

coverages included in the lines of business described in the annual statement as workmen's compensation, liability other than auto (B.I.), and auto liability (B.I.) shall not be less than the following: for workmen's compensation, 65% of premiums earned during each year less the amount already paid for losses and expenses incidental thereto incurred during said year; for liability other than auto (B.I.) and auto liability (B.I.), 60% of premiums earned during each year less the amount already paid for losses and expenses incidental thereto incurred during said year.

The (Commissioner, Superintendent, Director) may, by regulation, prescribe the manner and form of reporting pertinent information concerning the reserves provided for herein.

(Ref: 1968 Proc., VOL. I, p. 115)

**Exhibit III**  
**ANNUAL STATEMENT FOR THE YEAR \_\_\_\_\_ OF THE \_\_\_\_\_**  
*Supplemental Information For the Illinois Department of Insurance*  
**Computation of Excess of Statutory and Voluntary Reserves Over Case Basis**  
**(Schedule "P")**

Source	(1) Premiums Earned <small>(Pg. 6, Part 2, Col. 4) (Calendar Year)</small>	(2) Percent of Premiums Earned Percent	(3) Premiums Earned Amount <small>(Col. 1X2)</small>	(4) Company Losses Incurred <small>(Add Parts of Respec. Acc. Yr., Sch. P, Part V)</small>	(5)	(6)
Accident Year	\$	%	\$	\$		
<b>Section A</b>						
Auto Liability (B.I.)		50				
1963					XXX	XXX
1964					XXX	XXX
1965	_____		_____	_____	XXX	XXX
Total					XXX	XXX
<b>Section B</b>						
Liab. other than Auto (B.I.)		40				
1963					XXX	XXX
1964					XXX	XXX
1965	_____		_____	_____	XXX	XXX
Total					XXX	XXX
<b>Section C (See note 4)</b>						
Homeowners Liab. & C.M.P. Liab. (B.I.)		40				
1963					XXX	XXX
1964					XXX	XXX
1965	_____		_____	_____	XXX	XXX
Total					XXX	XXX
<b>Section D</b>						
Workmen's Compensation		55				
1963					XXX	XXX
1964					XXX	XXX
1965	_____		_____	_____	XXX	XXX
Total					XXX	XXX
<b>Section E</b>						
Auto Liability (P.D.)		50				
Calendar Year						
1963					XXX	XXX
1964					XXX	XXX
1965	_____		_____	_____	XXX	XXX
Total					(5)	(6)
<b>Section F</b>						
Liab. other than Auto (P.D.)		40				
Calendar Year						
1963					XXX	XXX
1964					XXX	XXX
1965	_____		_____	_____	XXX	XXX
Total					\$	\$
<b>TOTAL</b>						
Sec. A, B, C, D, E & F						
1963						
1964						
1965	_____		_____	_____		
Total						

Carry out for Additional  
each year: Reserve  
Amt. Stated Required  
in Col. 3 or 4 \_\_\_\_\_  
(whichever is Col. 5  
greater) minus  
Col. 4

## Exhibit IV

Policy Year	Source	(7)	(8)	(9)	(10)	(11)
		Number of Suits	Amount Charged for Each Suit	Total Suit Liability	Company Res. for Liab. Losses	
		Sch. P, Part I (Col. 9)		(Col. 7x8)	(Sch. P, Part I Col. 12)	
		#	\$	\$	\$	
<b>Section A</b>						
Auto Liability (B.I.)						
1961 & Prior			1,200			
1962			1,000			
<b>Total</b>						
<b>Section B</b>						
Liab. other than Auto (B.I.)						
1961 & Prior			1,200			(11)
1962			1,000			Additional Reserve Required
<b>Total</b>						
<b>Section C (See note 4)</b>						
Homeowners Liab. & C.M.P. Liab. (B.I.)						
1961 & Prior			1,200			Col. 9 minus Col. 10
1962			1,000			\$
<b>Total</b>						
<b>Total A, B, &amp; C</b>	<b>XX</b>		<b>XX</b>			

## Claim Expense Reserve Adequacy Test

Source	(12)	(13)	(14)	(15)	(16)
	Reserve for Liability Losses	Percent	Total Expense Res. Required	Company Reserve for Loss Expenses	
	(Sch. P, Col. 12)		(Col. 12x13)	(Sch. P, Col. 12½)	
	\$	%	\$	\$	
Coverage			X		
Auto B.I.			X		
Auto P.D.			X		
<b>Total</b>		15			(16)
Other than Auto (B.I.)			X		Additional Reserve Required
Other Than Auto (P.D.)			X		
<b>Total</b>		20			
Homeowners Liab. & C.M.P. Liab. (B.I.)		10			If Col. 14 is greater than Col. 15 show the difference.
Workmen's Comp.		10			
<b>TOTAL</b>					

Exhibit V

Summary

Losses and Loss Adjustment Expense	Additional Reserve Required by Illinois \$
Total Section A, B, C, D, E & F (1963-1965) (Col. 6)	_____
Total Section A, B, & C (1962 & Prior) (Col. 11)	_____
Total Adjustment Expense (All Lines) (Col. 16)	_____
TOTAL	_____
Less Equity in Schedule "P" (Page 3, Line 16 NAIC Statement)	_____
Net Decrease in Surplus (See Note 7)	_____
Adjusted Surplus for Illinois Department of Insurance Surplus in Page 3, Line 27, NAIC Statement	_____
Less Net Decrease in Surplus (Above)	_____
Adjusted Surplus	_____

NOTES AND INSTRUCTIONS

1. All information for the Illinois Supplemental Statement is available in the present NAIC Statement, except Sections E and F which can be secured from each of the last three Annual Statements.
2. All B.I. Liability and Workmen's Compensation figures to complete this form come from Schedule "P" and Page 6 of the Annual Statement. The Earned Premiums for these lines are Calendar Year and the Losses are Accident Year.
3. Auto Bodily Injury coverage includes the Uninsured Motorist coverage. However, if your Annual Statement also includes Medical Payments and Death and Disability in with the Auto Bodily Injury and Liability Other than Auto B.I. figures, use the combined figures as shown in the Annual Statement. It is assumed the combination of coverages for Liability shown on Page 6 is the combination used for Schedule "P".
4. Use 7½% of the combined Homeowners and Commercial Multi Peril coverages as the Bodily Injury portion of the earned premium, or as reported in Schedule "P" of the NAIC Statement.
5. Property Damage loss and expense figures are on a Calendar Year basis instead of an Accident Year basis, and may be found in Pages 6, 8 and 9 of the Annual Statement. The company, at its option, may substitute Accident Year statistics.
6. Use dollars only in completing this form.
7. If the total equity in Schedule "P" (Pg. 3, Line 16, NAIC Statement) is greater than the total additional reserve, show nothing (zero) for this line.

Insurance Accounting and  
Statistical Association  
May 28, 1968  
Session 459  
Schedule P

The Merits of Calendar/Accident Year Data In Schedule P

Robert A Bailey

Michigan Insurance Department

Background

About 50 or 60 years ago when workmen's compensation and automobile liability insurance were first beginning and when general liability insurance was increasing in importance in an industrialized society, the insurance regulators recognized the need for a test of reserves for the unpaid claims in these lines of insurance. Some insurance company managements had gotten into financial difficulty because they failed to set up adequate loss reserves.

Schedule P was first adopted by the Michigan Insurance Department and later modified and adopted by all insurance departments to provide a test of the adequacy of the reserves reported in previous annual statements and also to set a minimum for the current reserves.

In setting a minimum reserve it was necessary to relate loss reserves to premiums. In those days before the punch card and the ball point pen, the only feasible method of relating premiums and losses for individual coverages was the policy year method. The premiums for policies written during a year were compared with the losses for the same policies. The policy year was used for ratemaking for the same reasons. Schedule P accordingly used the same method that the ratemakers used.

However, the policy year method has a serious drawback. The most current policy year is always incomplete and by the time a policy year becomes fully complete, it is too old to be useful. An incomplete policy year requires so many adjustments before it can be used that it is quite unreliable.

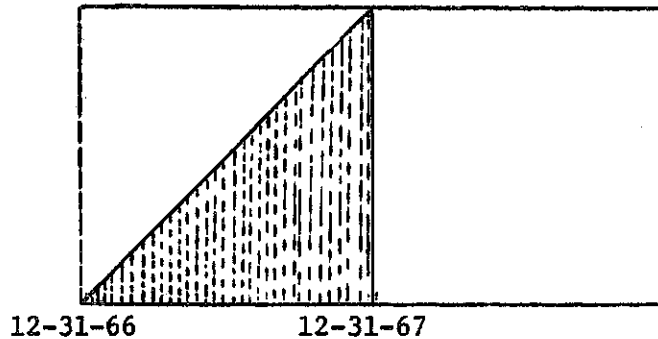
For these reasons the ratemakers have switched to an accident year or calendar year basis wherever possible because it gives more meaningful data faster.

Two subcommittees of the NAIC, the actuarial subcommittee and the subcommittee to study model legislation for Schedule P have both recommended that Schedule P be changed to a calendar accident year basis from a policy year basis in order to provide data that is more meaningful, more current and simpler.

Policy Year Data Obscures Reserve Inadequacies

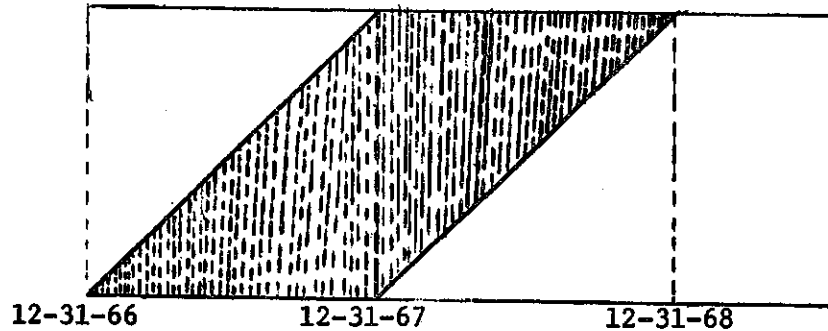
Schedule P shows the experience separately for each of the latest 8 policy years. The purpose of this is to permit a comparison of the same policy year as of 8 different reporting dates. The idea is that any change from one reporting date to another will reveal the adequacy of loss reserves. But that is not true with policy year data, at least for the first 3 or 4 years.

As of 12-31-67, policy year 1967 looks like this, assuming annual policies:





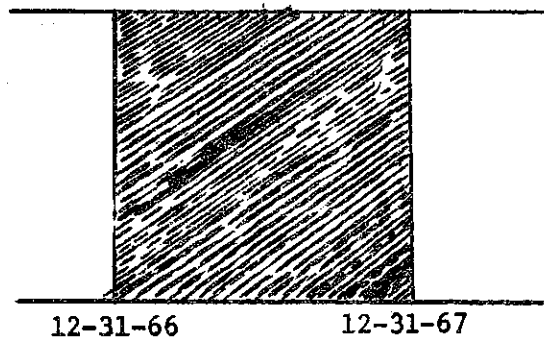
A year later it looks like this:



There are 3 reasons for possible changes in the loss ratio of policy year 1967 between the first 2 reporting dates of 12-31-67 and 12-31-68, only one of which is changes in loss reserves. One other reason is that at the second reporting date policy year 1967 includes accidents incurred in 1968 along with premiums earned in 1968. So any change in loss ratio does not necessarily indicate reserve inadequacies.

The other reason for change is that the earned premiums are understated in the first reporting. In workmen's compensation, general liability and commercial automobile insurance, many policies are written with an initial deposit premium which usually turns out, at final audit, to be about 20% less than the final audited premium. The additional audited premiums are not billed until about 90 days after expiration of the policy which means they are not all in until the third reporting of a policy year. So at the first 2 reportings the earned premiums are understated and any reductions in loss ratio for at least the first 3 years may be due to premiums coming in rather than reserve redundancies.

Now look at what an accident year looks like:



An accident year at first reporting is complete. It contains about twice as much premium and losses as the same policy year. What's more, the premiums and losses don't change after the first reporting so that any change in loss ratio is due entirely to loss reserve changes. The earned premiums are not understated like the policy year premiums because they include a full year's worth of audited additional premiums. Although the audits coming in during a calendar year are from policies written in previous years, they are a close approximation to what the future audits will be on policies written in the current year.

The policy year may be more accurate in matching premiums and losses after 3 years but by that time it is no longer used in the Schedule P minimum reserve formula which uses only the most recent 3 years. The accident year is more accurate and more conservative for the 3 year minimum reserve period.

#### Policy Year Premiums Understated

If the deposit premiums average 80% of the final premiums, the policy year earned premiums are understated by 20% at the first reporting. That is enough to raise a 60% loss ratio to 75%. Since the minimum loss ratio is 65% for workmen's compensation, this would permit an insurer to understate its loss reserves without

penalty. About  $\frac{3}{4}$  of the audits would come in during the second year leaving the policy year earned premium understated about 5% at the second reporting. With some policies written for 3 year terms and with retrospective rating adjustments, the premiums keep straggling in for 5 or 6 years in some cases.

To illustrate the effect this understatement of earned premiums has on policy year loss ratios, the loss ratios for policy year 1965 were calculated for 3 large workmen's compensation insurers using the incurred losses reported in 1967 and the earned premiums reported in 1965, 1966 and 1967:

Policy Year 1965 Loss and Loss Expense Ratio  
Losses valued as of 12-31-67, Premiums reported as of:

	1965	1966	1967
Liberty Mutual	77%	71%	69%
Aetna C & S	92	77	74
Employers Mutual	81	70	68

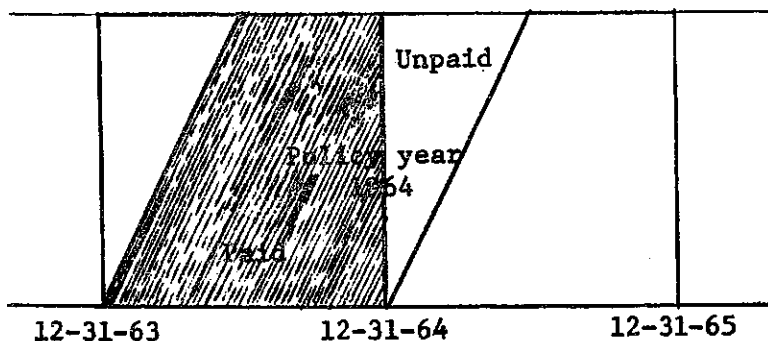
The reduction in loss ratio was due to premium increases. The accident year method would have more correctly stated the premiums and would therefore have produced a more conservative minimum reserve requirement.

Policy Year Data Makes a Test of Current Reserves Impossible

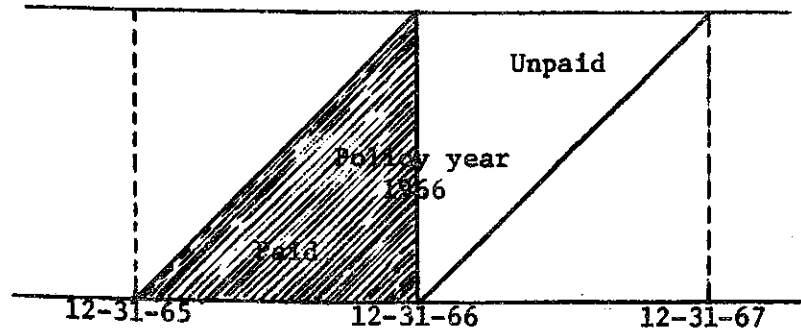
Schedule P tests the adequacy of reserves reported in previous annual statements and it establishes a minimum reserve for the current reserves. Did you ever wonder why Schedule P does not include a test of the adequacy of current reserves? That is what we are most concerned about. The reason is that the policy year basis makes it impossible to test the current reserves.

To test the current reserves, we would have to compare the reserves for each policy year in the current annual statement with the reserves for comparable policy years at the same stage of development in previous annual statements. For example, we would compare the reserves for policy year 1966 in the 1967 annual statement with policy year 1965 in the 1966 statement and with policy year 1964 in the 1965 statement and so on as far back as we wanted.

Let's assume every loss is paid one year after its date of occurrence and let's also assume the insurer wrote 6 months policies until 1965 and then switched to annual policies. The reserves for policy year 1964 in the 1965 annual statement would have been  $\frac{1}{4}$  of the total incurred losses. The policy year would have looked like this:



But with a switch to annual policies the reserves for policy year 1966 in the 1967 annual statement would be  $\frac{1}{2}$  of the total incurred losses. The picture would look like this:



This shows how any change in the length of policy terms or any change in the distribution of effective dates throughout the year would make comparisons of different policy years meaningless. The same applies for comparisons of the same policy year for different insurers.

Because the accident year is unaffected by the length of policy terms or by the distribution of effective dates throughout the year, valid comparisons are possible with previous accident years at the same stage of development and with other insurers. The NAIC actuarial subcommittee has capitalized on this advantage of accident year data and has proposed a new Part 6 for Schedule P which tests the adequacy of the current reserves by comparing them with previous reserves.

#### Accident Year Data Is Simpler

Accident year data is not only more meaningful and more current, it is also simpler to compile. It eliminates the need to record written premiums and unearned premiums by policy year and it eliminates the need to calculate formula loss reserves by both policy year and accident year as is currently required. Accident year data will simplify Schedule P, which certainly needs simplification.

#### Broadening Schedule P

Another change proposed for Schedule P by the NAIC subcommittees is a model law which sets a "minimum minimum" for Auto BI, Other BI, and workmen's compensation at the present 60% and 65% levels and permits the commissioners to adopt higher percentages and to include other lines of insurance in Schedule P as conditions warrant.

The present requirement of including only the BI portion of homeowners and commercial multiple peril policies without specifying exactly how much of the premium is to be included, permits an unscrupulous company to adjust its premium allocation at will and thereby completely circumvent the purpose of the minimum reserve requirement. The same applies in lesser degree to auto BI, especially for companies that use package rates for BI and PD or for all auto coverages. The proposed legislation is designed to permit the broadening of Schedule P to include entire lines of business where premiums are more explicitly defined so as to avoid the manipulation of premiums that is presently possible.

The thought is that eventually it may be decided best to set up a separate Schedule P for the entire homeowners and commercial multiple peril policies, not just the BI liability portions thereof. This would be possible under the proposed legislation, but is not possible under existing legislation. There is also sentiment in many quarters to raise the minimum percentages of 60% and 65% to a more realistic level. Again this is possible under the proposed legislation which sets the 60% and 65% requirements as "minimum minimums" but is not possible under existing legislation.

The present requirement to segregate premiums on a basis no longer consistent with the way insurance is written nowadays, imposes burdensome accounting requirements on the responsible companies and at the same time opens the door for other companies to manipulate their premium allocations to correspond to their reserving

practices. So you can see that both the commissioners and the responsible company managements stand to gain from the proposed changes.

Because of the importance of Schedule P in testing the loss reserves, we believe it is important that everyone involved have ample opportunity to study the recommended changes. We are hopeful that these much needed changes which will improve our ability to regulate for solvency, will receive the enthusiastic support of all the commissioners and the responsible company managements at the June meeting of the NAIC.

## SENTRY INSURANCE

Stevens Point, Wisconsin 54481

June 13, 1968

Dr. Clyde H. Graves  
Portland Hilton Hotel  
Portland, Oregon

Dear Doc:

I have your Uniform Accounting Committee circular dated June 10, 1968 in connection with Schedule P. These are my comments with respect to the material in that circular.

1. The letter dated June 5, 1968 from Hon. David J. Dykhouse to Roger Kenney.

I have no particular comment on this letter. It speaks for itself. I am attaching a letter that I wrote to Mr. Kenney in connection with his two articles on Schedule P. As you know, I disagree with the proposed no change of Parts 3 and 4 of Schedule P and in the event you don't have this memorandum with you, a copy of it is attached.

2. Letter dated May 24, 1968 from New York Insurance Department.

It is difficult to criticize the New York Insurance Department's position paper without writing a book on the subject. The paper in my opinion has been directed toward persuading those individuals who are not too familiar with Schedule P. Knowledgeable Schedule P experts are not impressed with the arguments in the paper.

It is also apparent from the position paper that the New York Insurance Department does not have a complete understanding of the proposed new Parts 6A, 6B, 6C and 6D. Because the new parts include loss expense, such information is not available by "hand calculations" from other exhibits in the statement (see the statement on Page 840). Again on (Page 844) the statement is made: "The proposed new Parts would not furnish a comparison of current reserves with previous reserves since the data in respect to the latter would not be shown."

Part 6 is a prospective evaluation and any comparison of current reserves with unadjusted previous reserves would have little value to the analyst. The comparison with prior adjusted reserve levels as proposed is the only meaningful comparison. Obviously from these two statements it does appear that the new Part 6 has been misunderstood by the New York Insurance Department.

I would particularly like to comment on the reference made on (Page 842) to my paper: "There is little question that calendar-accident year ratios are theoretically less accurate than policy year ratios." This quotation is correct, but misleading when taken out of text. My paper goes on to say: "However, it is to be remembered that the primary purpose of Schedule P is to assist in the determination of adequate reserve levels—not the precise measurement of loss ratios."

In connection with Parts 3 and 4, the New York Insurance Department raises an excellent "question as to the consistency of position on the part of the proponents" when the policy year percentages are transferred without change to accident year. I'm sure you are aware that I am very definitely opposed to this part of the proposal and share the criticism made by the New York Insurance Department. However, I disagree with the statement in the position paper (Page 840) that a change to accident year basis "could not be done because of their inability to obtain Unallocated Claim Expenses by 'accident year'". A much sounder position is the one recommended in my paper which would convert the present policy year distribution percentages to an accident year basis. The only available basis for this conversion is the one presently set forth in the IASA Insurance Accounting Fire & Casualty, Second Edition, 1965, Page 168. Many companies today are using these percentages for unallocated loss expense reserves. Even though such percentages would likewise be arbitrary, their adoption would be consistent with the intent of the change and, therefore, would limit the criticisms to the calendar/accident year concept only.

On (Page 844) in connection with the function of Part 5, the position paper indicated that Schedules G and O reflect similar information in respect to other lines of insurance. The similarity reference being made to Part 5. Again there

must be some misunderstanding of the proposal by the New York Insurance Department because the proposed rearrangement of Part 5, which provides reserve developments for the line as a whole, makes it more similar to Schedules G and O than Part 5 is in its present form.

There is no question in my mind that the change of Schedule P to a calendar/accident year basis together with its additions and modifications will considerably improve the value of Schedule P. Perhaps it takes too much imagination to foresee all of these benefits. It is particularly discouraging to think that the proposal may be turned down because of the rather subjective arguments presented by the New York Insurance Department.

In conclusion, I think we must compromise with the New York Insurance Department by accepting its criticism in connection with Parts 3 and 4. This criticism is just and it can and should be accommodated. It may even be the basis for getting acceptance from both sides.

Yours very truly,

Ruth Salzmann  
Vice President and Actuary

#### SENTRY INSURANCE

April 12, 1968

Mr. Roger Kenney  
Insurance Editor  
United States Investor  
286 Congress Street  
Boston, Massachusetts 02210

Dear Mr. Kenney:

I read with considerable interest your two articles on Schedule P in the April 1 and 8 issues of U. S. Investor. Enclosed is a copy of the paper I presented to the Casualty Actuarial Society a year ago from which a good portion of the proposed changes in Schedule P originated. I think when you read this paper, you will agree that the annual statement changes recommended are consistent with your philosophy of adequate loss reserves in the casualty business—and the providing of a vehicle to evaluate such adequacy.

Just a minor point but you will note that my proposal does recommend a change in the present Parts 3 and 4 to reflect the conversion from policy year to accident year.

Very truly yours,

Ruth Salzmann  
Vice President and Actuary

## Criticisms of Parts 3 and 4

As proposed by the (F5) Subcommittee

In the new Schedule P on a Calendar Accident Year Basis

by Ruth Salzmann

Member of the Industry Committee

The (F5) Subcommittee proposal relating to Parts 3 and 4

"It should be noted here that while no change is necessary in Parts 3 and 4 of Schedule P, and none was recommended by the members of the (F5) Subcommittee present at our Hartford meeting, the industry committee would prefer to reduce the requirements in Parts 3 and 4. No change in Parts 3 and 4 will produce reserve requirements for unallocated claim expense under an accident year basis which will be never less than present requirements under a policy year basis. A few insurers, whose policies all expire on December 31, each year, will continue with the same requirements as before. All other insurers will have higher reserve requirements for unallocated claim expense, the amount of increase depending on what proportion of premiums written during one year are earned in later years. The industry committee would prefer to reduce the requirements in Parts 3 and 4 such that the reserve requirements would be unchanged for an insurer writing only annual policies with effective dates that are evenly distributed throughout the year. Such a change in Parts 3 and 4 would increase the reserve requirements for some insurers and decrease them for others, from the present policy year requirements. The members of the (F5) Subcommittee believe there is a distinct possibility that the present requirements are inadequate and recommend no reduction until evidence is furnished that they are excessive."

## Comments

1. First of all it should be noted that Parts 3 and 4 of Schedule P are Exhibits in the annual statement which distribute unallocated claim expenses paid by policy year now and by accident year in the proposal. This distribution in itself has little financial impact. However, the distribution percentages are significant when such percentages are used to calculate the unallocated claims expense liability. This is why the above paragraph concerns itself with "reserve requirements". The actual statutory percentages incorporated in Parts 3 and 4, therefore, are of vital importance to the industry.
2. Secondly, the above paragraph states "while no change is necessary in Parts 3 and 4 . . . the industry committee would prefer to reduce the requirements in Parts 3 and 4". This statement carries the possible inference that the industry committee wants to reduce present requirements. A more precise statement would be that the industry committee wants to maintain the reserve levels generated by the present statutory percentages. The reserve levels proposed by the (F5) Subcommittee are considerably higher than present requirements in general. Note the statement which reads: "no change . . . in Parts 3 and 4 will produce reserve requirements . . . under an accident year basis which will be never less than present requirements under a policy year basis". Exhibit 2 provides a comparison of the difference in the proposed requirements and those requirements accepted by the industry at the present time. Exhibit 1 shows the reconciliation of the present and proposed distributions by accident year to current policy year percentages. It is interesting to note that these are the only two possible distributions of calendar year expenses by accident year which will equate to the present policy year percentages.
3. It is my opinion that the transition in Schedule P from a policy year basis to a calendar year basis should be considered on the merits of this change alone. Therefore, I believe that we should maintain the status quo in all other aspects as of this time. The accuracy of one distribution over another should be deferred until later; the important concern should be the merits of the calendar/accident year basis and its fringe benefits. As a result, let's not rock the boat; let's stay with the percentages by accident year included in the IASA book "Insurance Accounting Fire and Casualty", second edition, 1965, page 168. (Exhibit 3 is included to show that the proportion of policy year premiums earned in the first 12 months for the leading insurance carriers is relatively close to 50%; 59.7% in Auto B.I. and 51.2% in W.C. To the extent that earned premiums reflect the earned exposure by accident year, the IASA percentages are more appropriate if we are to maintain any continuity in the transition.)

4. Exhibit 2 as noted above shows the difference in the liability requirements that would be produced by the percentages proposed. Because many carriers use the statutory percentages in establishing unallocated expense liabilities, one can note the significance of the proposal by the (F5) Subcommittee. This difference becomes all the more important with the adoption of the new Part 6. The new Part 6, which includes all claim expense, requires that claim expense liabilities reflect all future expense charges. Thus, if the new Part 6 is adopted (and I hope it will be) the statutory percentages incorporated in Parts 3 and 4 take on added significance. This is another reason why we should attempt to continue the present reserve level requirements. Otherwise we may sabotage the entire calendar/accident year concept.
5. For the above reasons, particular exception is taken to the argument supporting the (F5) Subcommittee proposal, "The members of the (F5) Subcommittee believe there is a distinct possibility that the present requirements are inadequate and recommend no reduction until evidence is furnished that they are excessive". The merits of the calendar/accident year basis are completely independent of the furnishing of such evidence; and a decision on the former should not be tied to or delayed by the latter.



Exhibit 1

Possible Distributions of Calendar Year  
Unallocated Compensation Claim Expenses  
by Accident Year equating to Present Policy Year  
Policy Year

Accident Year	1968	1967	1966	1965	Total
1. Acc. Yr. (n) distribution: 50% (n) Pol. Yr. - 50% (n-1) Pol. Yr.					
1968	40	40			80
1967		5	5		10
1966			5	5	10
1965					0
Total	40	45	10	5	100
2. Acc. Yr. (n) distribution: 100% (n) Pol. Yr.					
1968	40				40
1967		45			45
1966			10		10
1965				5	5
Total	40	45	10	5	100

Exhibit 2

Calculation of

W.C. Unallocated Loss Expense Liability  
using statutory percentages in Schedule P

Policy Year	Accident Year	% Applied 1968	Future % 1969	% to be applied in: 1970 1971		
1. IASA text, Second Edition, 1965, p. 168 (Distribution 1 on Exhibit 1)						
1965	1966	5	—			
1966	1966	5	—			
	1967	5	5			5
1967	1967	5	5			5
	1968	40	5	5		10
1968	1968	40	5	5		10
Total		100	20	10	0	30
2. F-5 Subcommittee Proposal (Distribution 2 on Exhibit 1)						
1965	1965	5	—			—
1966	1966	10	5			5
1967	1967	45	10	5		15
1968	1968	40	45	10	5	60
Total		100	60	15	5	80

## Exhibit 3

% of Pol. Yr. Prem. Earned in 12/24 Calendar Months

Auto B.I.: Companies exceeding \$100,000,000 Prem. earned in 1966 Cal. Yr.

Company	1966	1965 Policy Year	
	Cal. Yr.	12-31-65	12-31-66
Aetna Life Group	179,856,830	100,592,553	164,223,325
Allstate Group	354,161,812	174,040,955	328,506,097
Cont. Ins. Cos.	109,309,328	41,704,562	96,744,529
Hartford A&I	161,826,289	89,084,261	155,597,414
Liberty	110,949,618	60,932,433	101,065,211
Nationwide Mutual	119,806,205	79,841,033	113,084,147
State Farm Mutual Auto	434,510,631	217,712,870	297,160,883
Travelers Group	191,800,741	107,043,388	202,130,868
		<u>870,952,055</u>	<u>1,458,512,474</u>
%		59.7	100.0

W.C.: Companies exceeding \$75,000,000 Prem. earned in 1966 Cal. Yr.

Aetna Life Group	143,183,805	65,156,711	127,532,222
Amer. Mut. Liab. Cos.	79,184,895	38,270,285	74,926,081
Employers Mutual	133,865,652	61,450,451	119,881,218
Fireman's Fund-Amer.	87,591,983	37,412,050	77,940,931
Hartford A&I	92,510,301	43,023,470	86,240,841
Liberty	207,848,390	104,930,293	195,882,686
Travelers Group	85,096,158	39,055,207	78,010,623
		<u>389,348,467</u>	<u>760,414,602</u>
%		51.2	100.0

To Consider Premium Financing by Insurers (F6) Subcom. Report  
(Mtg. 12)

The (F6) Subcommittee met at 10:00 a.m. June 17 in the Galleria 2 Room, Portland Hilton Hotel, To Consider Premium Financing by Insurers.

The Chairman reviewed the action taken at the December meeting in Honolulu wherein it was the Subcommittee's recommendation that the scope of the Subcommittee's authority be expanded to review the entire field of premium financing by insurers or otherwise. The (F6) Subcommittee's report was adopted by the (F) Committee which, in turn, was adopted by NAIC. Therefore it is my opinion that this Subcommittee's authority was so broadened.

The Chairman received reports from the following:

1. John Daniels, Chief Deputy, North Carolina Insurance Department spoke on "experience and regulation of premium financing."
2. R. Donald Beard, Executive Vice President, IFCO, Inc., Fayetteville, North Carolina who spoke on "health and well being of a servicing company."
3. G. I. Johnson, Virginia Insurance Department who spoke on "premium financing."
4. Edward W. Horne, Vice President and General Counsel, AFCO, New York City, spoke on "premium budgeting."

The Florida Insurance Department suggested that the subject of reinstatement of policies that had been premium financed should be studied. The problem stems from the fact that the premium finance company has authority to cancel the policy and receive the unearned premium but does not have the authority to order reinstatement of the policy when the insured borrower has paid his past due balances.

There were no further comments and the Subcommittee went in Executive Session. In Executive Session, Mr. Eddie Germann of the California Insurance Department advised that it was their recommendation that the reinstatement problem was of concern.

Commissioner Blaine of Idaho did move that the Subcommittee's title be amended to read as follows: "To Consider Premium Financing by Insurers or Otherwise." It was seconded by John C. Daniels and passed.

It was also moved, seconded and passed that the Subcommittee try to ascertain the extent of the problem on reinstatement.

The State of Michigan submitted a report to the Subcommittee and it, together with the reports of Mr. R. Donald Beard, G. I. Johnson and Edward W. Horne are attached hereto.

Hon. J. Richard Barnes, Chm., Colo. by Robert L. Brown; Hon. John R. Blaine, Idaho; Hon. Newton I. Steers, Jr., Md.; Hon. David J. Dykhouse, Mich.; Hon. Edwin S. Lanier, N. C. by John C. Daniels.

NORTH CAROLINA  
ASSOCIATION OF PREMIUM SERVICE COMPANIES, INC  
The Health and Well-Being  
of a  
Premium Service Company

So that a Premium Service Company may operate in a reasonably healthy climate and serve the needs of the insurance agent and his client, certain factors must exist and contribute to this health, or a state of failure will develop even to the point of collapse or bankruptcy. It is felt that there are five factors of major importance that contribute to the success of a healthy Premium Service Company, and they are:

- I. Good Legislation
  - II. Good Insurance Department regulations and enforcement
  - III. Good Management
  - IV. A good Trade Association
  - V. Good relationship to insurance companies and the public
- I. Good Legislation
1. Adequate service charges, but not excessive charges, are needed. Certain minimum expenses per contract or transaction demand a minimum fixed charge. \$10.00 seems to be a fair minimum plus a stated maximum interest charge. These charges should be all the charges allowed; no late, cancellation, or other hidden charges should be allowed. The finance contract should give the unearned premium only as collateral, and nothing else such as claim assignment.
  2. We have learned from other fields of financing that "finder's fees" or "kickbacks" get out of hand and must, when they are given, be added to the cost to the consumer. Already, when unregulated in some states, the Premium Service Industry has experienced an out of hand "kickback" practice which is excess cost to the consumer or insured. The best advice is to legislate as "unlawful" any "kickbacks", or any inducements whatsoever, to the producing agent.
  3. Legislation should provide that only insurance premiums may be included on the contract, which will exclude motor clubs. Already, where unregulated, the practice of adding motor clubs has existed only to serve as "additional cost" and not really a wanted or needed service.
  4. Good legislation should require financial strength in the form of a bond. This means the bonding company is doing some underwriting, or eliminating some undesirables, before the regulator or the Insurance Department is confronted with licensing such applicants. Care should be taken here in not setting this bond too low. Errors and Omissions insurance would be preferred. In fact, whether Errors and Omissions insurance is required or not by legislation, it seems the company issuing the bond would be very much interested in the Premium Service Company having Errors and Omissions insurance for their added security.

5. Cancellation privileges, given to the Premium Service Company by use of the Power of Attorney given by the insured, need strict rulings. This should be limited to use only after certain notices, and certain time elapsed, before the Power of Attorney can or may be of value for use as authority to cancel. Care should be given to see that the insured receives his refund, if any, after cancellation.
6. Adequate license tax, to pay all cost of Insurance Department's cost of regulation, should be fixed. The Premium Service Industry should not be a financial burden, but self supporting. Certainly \$10.00 license fee will not pay for regulating. One state in charging \$950.00 per year for license, and is doing a good job of regulating.
7. A lender to a Premium Service Company does not have to look very deeply into its risk to see the value of good legislation, and enforcement by the Insurance Departments greatly affects the security of the loan.
8. It seems that model legislation with standard forms from the NAIC could, and should, be forthcoming and this Premium Service Association offers its services if called upon. The experience of several states is already available to work from.

## II. Good Insurance Department enforcement

1. After proper public hearings, additional rules and regulations should be set forth by the Insurance Department. These will, of necessity, have to be altered with time.
2. Care should be given in selecting the correct supervisor in each Insurance Department, to assign with adequate authority, to supervise all applicants and licensees. This supervisor should begin, and continue to supervise with firmness, to assure all licensees that only legal and fair practices will be tolerated. Examination and inspection on the scene, as well as in the field, of the Premium Service Company, should be common practice. A certified annual audit is definitely desirable, as then no one is left guessing as to what the score really is.
3. Financial stability should be number one before licensees are issued or renewed. Care should be taken to assure that co-mingling of funds from any other business does not exist.
4. Along with the emphasis placed on the need of bond requirements, we place the importance of determining the morals of the management and field men of a licensee. "Fast Buck Artists" have been known to be attracted to this industry and greatly muddy the water.

## III. Good Management

1. A background of insurance has proven to be most helpful in this industry. It seems that the worst background of management comes from the small loan industry experience.
2. Whether the law or rules and regulations require Errors and Omissions insurance, good management should definitely require this themselves. A lender should equally be interested in Errors and Omissions insurance.
3. Office procedures and practices soon determine the direction a Premium Service Company will travel; up or down, sink or swim. Also, the good producing agent will only tolerate good office practices as well as other quality services.
4. The organization should be one organized to perpetuate at the death or disability of any of its executives.
5. Large sums of money must be had, or available, as growth develops; and growth with development, or sinking will be forthcoming.
6. One of the fastest deaths to a Premium Service Company can and will come if proper guards are not maintained against "bogus" or "fictitious" contracts from a producer. Poor management and poor selection of agency producers are the invitations to bogus contracts.
7. Here again a lender needs to take a double look at the safeguards the management has in this area to determine the security of a loan to a Premium Service Company.

## IV. Good Trade Association

1. Commissioner Gambrell of South Carolina wisely said, immediately after their Premium Service law was signed into law, that the interest of all concerned would be better served if his department could deal or talk with a representative of the industry, rather than every licensee or applicant coming to him with their separate problems and questions. Needless to say, a Premium Service Association of South Carolina was quickly organized.
2. An association causes one to sit at the same table and possibly break bread with his competitor, and this is good.
3. Policing its own industry is one of the chief purposes of an association.
4. In North Carolina, annual seminars held by the Association, with appreciated help from the Insurance Department, have been most helpful.
5. An association can more effectively promote needed legislation and defend the industry and public against unfavorable proposed legislation.

## V. Good Relationship to Insurance Companies and the Public

1. This can be aided by a Trade Association.
2. A Premium Service Company should not only always be legally right, but morally fair to the producing agent and the client. The laws can only cover certain areas, but the laws of good morals cover all areas at all times. You only need a conscience to guide you.
3. With few exceptions, insurance companies have been extremely fair and cooperative before and after legislation on premium service. Insurance companies' cooperation is a must, and lack of consideration on the part of some premium service companies does ask for trouble for all concerned. In other words, there should be a very close and good working relationship between these two interested parties.
4. A Premium Service Company should never ask or expect an insurance company to do for them what the Premium Service Company can and should do for themselves.

You may have already noted that there has, until now, been no mention made as to volume of business, although this is the life blood in the "Health and Well-Being of a Premium Service Company". The thought is that if all these stated practices are sincerely and diligently followed, the volume will be forthcoming, as the public needs this service. This is a necessary and demanding part of the Insurance Industry. Today's living and business practices demand credit. Detroit does not quote the price of an automobile at \$147.00 per month, but \$4,300.00 cash. The TV and appliance dealers get the cash, but a third party does make available, if needed, the monthly payment option. The third party system of financing has proven its value also in "Premium Financing" as to more flexibility and service. The unfavorable experiences, such as that of Cisco Group of Colorado, would have been totally avoided with my suggestion here today. Cisco's application for license was denied in North Carolina, due to management and their financial condition.

Also, the agent, with decreased commissions, just cannot continue to maintain accounts receivables as a free service. Please forgive me if I have tended to oversimplify the operation, as it is definitely not a simple matter.

I am G. I. Johnson, in charge of insurance premium finance companies in the Virginia Bureau of Insurance. Your Chairman has requested that I give the Committee the benefit of some of the experiences we have had in Virginia where we have been regulating premium finance companies for the last four years.

It would take more than my allotted time to discuss with you all of the problems the Insurance Department meets in the regulation of insurance premium financing and the companies licensed to carry on such a business. I will try to review with you some of the more important ones.

Whether we like it or not I am afraid premium financing will be with us for some time to come. We in Virginia had no desire to get involved, but found no other choice. As you know, premiums for insurance, especially automobile, have increased considerably in the past ten years. The underwriting for automobile insurance has become more restrictive. This has required the agent to place more and more business through the Assigned Risk Plan or else broker it through the sub-standard market where he does not have an account current. Due to the premiums involved the insured cannot pay cash and many agents do not have the capital to carry him on open account. Since many of these insureds do not enjoy the best of credit, and lending facilities are not immediately available, premium financing has become a natural.

Prior to the enactment of our law an agent in our State was collecting \$6.00 per week from an insured of which more than \$3.00 was being charged as interest. Usury? Yes, but who was to enforce it since this type of lending was not covered by a regulatory department in our State. This is a little of the background as to why Virginia enacted a Premium Finance Law.

In 1965 approximately 52,000 contracts with over \$8,000,000 involved was financed. In 1966, over 64,000 contracts with over \$9,700,000 were financed and 1967 more than 88,000 contracts with more than \$12,800,000 were financed. From this you can see the trend in using Premium Financing is upward.

Like everything else there are pros and cons in Premium Financing. It goes without saying that whether it is a pro or a con depends on which side of the table you are sitting. Without question it has caused extra paper work for insurance companies. A fourth party has been brought into the picture, which means another opportunity for an error to be made in handling the account. It has also enabled certain insureds to purchase insurance who would not have been able to raise the money otherwise.

Most of the problems confronting Premium Financing could be solved if everyone lived by the Golden Rule. Needless to say this will never be accomplished.

In order for a premium finance company to operate with a minimum of problems it is necessary for the person or persons making the decisions to have a knowledge of insurance. Yet, surprisingly some of the key personnel do not know what pro-rated or short-rate cancellations are. An insurance calculator commonly referred to as a "wheel" has never been heard of. The only thing they know or care about is whether the account will pay out with the return premium they receive. They have no concern whether the insured gets what is coming to him or not.

By making routine calls on the various premium finance companies we get an idea as to the manner in which the business is being operated. We also get an insight into how accurately and promptly an insurance company makes its refunds and how efficient an insurance agent is.

These checks reveal in many instances that the finance companies are only collecting the net return premium provided this would pay off the account. The failure to collect the unearned commission had the effect of a rebate to the agent at the expense of the insured. You should have heard the phone calls that came in from the agents when a stop was put to this practice. When the question "Whose money is this" was asked, the conversation was quickly brought to a close.

Requiring that the insured get a copy of the contract curtailed the practice of getting the insured to sign a contract in blank. You can imagine what was occurring before this practice was curtailed.

Bulletin #3 issued by our Department forbade notary fees, D.M.V. records and any other incidentals to the obtainment of insurance from being financed. These fees were being charged to the insured while being concealed in the contract. The net result was a rebate to the agent at the expense of the insured.

Many of the finance companies are operated and managed by high caliber people,

yet they are reluctant to put a stop to unethical practices for fear of losing business to a competitor who is willing to turn his head so long as he benefits. Once a Bulletin is issued by the Insurance Department the finance company can use this as a means to accomplish the objective without losing business to a competitor.

All premium finance companies have been directed in writing to notify the Bureau of Insurance of any violations of law or other irregularities committed by any agent or agency with which they are doing business. This includes bad checks and failure of an agent to settle his account with the finance company. We have also stated to finance companies that if they permit producers of insurance to collect monthly installments due the finance company the producer becomes an agent of the finance company, therefore payment to the producer is payment to the finance company whether it gets the money or not. One finance company has had to become responsible for payment of a claim which resulted after the finance company improperly cancelled a policy.

Many agents have or are considering getting a finance license. The usual practice is to operate the finance company under an assumed name to prevent the insured from knowing the agency and finance company are under the same management. Both operations are usually operated by the same personnel. This practice has necessitated our requiring either a street address or telephone number being on all forms used by the finance company. We found instances where the agent was blaming the finance company for the problem knowing that the only way the insured could get in touch with the finance company was by writing to a P. O. box number. Correspondence to this address may or may not be answered. It may be worthy of noting that where an agency has a premium finance company, we consider this two separate operations and require that separate records be kept for each operation.

We have received inquiries about credit life being written to cover the finance contract but we have not permitted this due to the fact that if the account is properly handled the unearned premium will always pay off the account.

There is an old saying "You can sell anything if you make the down payment low enough and the monthly installments are spread out far enough." Many agents operate on this theory and premium financing has created a means whereby agents can sell or in some instances, add in unnoticed an Accident and Sickness policy commonly referred to as "Med Pay", which is most limited. With a retrospective plan an agent's commission will be as high as 80%.

The loss ratio on these policies is frequently below 10%. The retrospective plan is not needed as there are no underwriting requirements. In my opinion the retrospective plan is a bad practice with this type of business as an agent with weak morals would be tempted to conceal information from an insured pertaining to his coverage. When the policy is found in the agents file the usual response is "I am holding the policy at the request of the insured so he will have it in a secure place."

One agency was not satisfied with the 80% so it kept all the premium on over nine hundred (900) policies in one year. Putting it another way, it wrote one out of three policies. Some of these policies were not written until after the insured had a claim. One policy had expired four months before the policy was written, yet the company paid the claim. Why the insureds or the insurance company never complained is beyond my comprehension.

We have not permitted "Motor Clubs" to be financed as under our Virginia law a motor club is not considered Insurance. This has eliminated one "add on" which the agents would be using.

Bogus contracts and various uses of Powers of Attorney are a speech in itself and is a constant concern of the Bureau of Insurance.

Many insurance companies will be surprised to learn that their agents have been cancelling policies pro-rata for non-payment to the insurance agent when in essence it should be cancelled short rate for non-payment to the finance company or some other lending institution where the agent co-signed a note.

I know of one instance where a general agent for a substandard company had a 90-day account current. This general agent would not accept any applications from a broker for which he did not receive cash. This general agent was getting 60% of his capital for the finance company from this account current.

Another agent was selling a mutual monthly fire policy which the insured financed on a yearly basis. This had to be stopped as the agent was using the money at the expense of the insured.

I do not wish to imply that everything involving premium financing is bad because it is not. Premium financing has filled a need but in doing so has created some problems. My sole intent was to convey to you some of these problems.



## Report of Edward W. Horne to the (F6) Subcommittee to Consider Premium Financing

## Introduction

I believe all premium finance companies are pleased that this Subcommittee is considering the subject of premium financing. We at Afco have always felt that premium financing is a vital catalyst to the insurance industry in the marketing and servicing of insurance policies. In this age of credit, it is necessary to provide a financing facility to the insurance buying public so that the public can purchase insurance to true value and pay for the same in installments which might not be the case if the public were required to pay for its insurance in cash in advance. Because installment payments are by and large a way of life today, if premium financing were not available to the insurance buying public, the insurance companies would be obliged to market insurance on an installment basis. This obviously would be financially burdensome to the insurance industry because the insurance companies need the premium payment in advance so that the premium is available for investment purposes. For this reason and also because premium financing operates to relieve the insurance producer from a collection problem to a large degree and provides the producer with his commission in advance, premium finance companies render a valuable service to the insurance industry as a whole.

## The Basic Method of Operation of a Premium Finance Business

Insofar as fire and casualty insurance policies are concerned, a premium finance company receives an assignment of the unearned premium payable under the financed policy from the insured. Where the financed policy is of the type where there is no unearned premium in the event of a loss payment, or where the premium is partially earned, in the event of a loss payment the premium finance company also receives an assignment of that portion of the loss payment payable to the insured which is still owed by the insured to the premium finance company. A down payment is required to be submitted to the premium finance company along with the request for the financing of the premium so that, in the event of a default, the premium finance company will not sustain a credit loss under the finance transaction. The usual method of insuring that a loss will not be sustained is for the finance company to take from the insured a power of attorney permitting to effect cancellation in the event the insured defaults in its installment premium payments to it. The premium finance company upon default in payment effects cancellation of the insurance policy in the same manner as the insured and receives the unearned or return premium. A number of companies engaged in premium financing in the United States have entered into agreements with insurers whereby the insurer when advised of the default of the insured under the finance transaction will at its option effect cancellation of the financed insurance policy and remit the unearned premium to the finance company, either directly or through agency channels. This method of operation has the benefit of insuring that the cancellation of the insurance policy is effected in accordance with policy provisions. Thus the premium finance company is concerned from a credit standpoint with the insurer whose unearned premium represents the collateral security to the transaction rather than with the credit worthiness of the insured.

In consideration for this service and the advancement of the full premium by the premium finance company there is a finance charge which varies in amount from state to state primarily because of variances in the local laws.

At first glance, the basic method of operation seems quite simple. Actually, the insurance business is perhaps one of the more complicated types of business carried on in the United States today and just as the insurance business is complicated so also is the premium finance business because it is inextricably related to the insurance business. Consider for a moment the problem presented to a premium finance company when an additional premium has been earned because of a surcharge or an increase in the risk or coverage. Likewise, the finance transaction is complicated by a reduction in coverage. In short, the premium finance company must stand ready to adjust its loan up or down in mid-term. It is further complicated by managing general agents, general agents, policy issuing agents, sub-producers and brokers not to mention variances in the policies of the insurance companies. To render service to all parties, the premium finance company must keep the various interested entities informed at every stage, which adds up to an unusual amount of paperwork.

In addition to the financing of domestic insurance company policy premiums, finance companies also finance premiums on policies issued by foreign insurers. The system which the N.A.I.C. inaugurated a few years ago in this area has been most helpful, but because the N.A.I.C. has not established minimum requirements for foreign insurers which may underwrite in the United States, these companies must

be looked into by premium finance companies as well as they are able in order to determine the company's eligibility for financing.

Once the eligibility of an insurance carrier for premium financing is determined to be acceptable to the premium finance company, it advances the premium and it remains for the finance company to collect the installment payments from the insured. This can develop into an expensive proposition. Not all insureds pay installments promptly. When a default occurs the premium finance companies send out delinquency notices and notices of intent to cancel the financed policies to induce payment of the defaulted installment. Because this additional service adds to the cost of operation of the premium finance company, most premium finance companies and most regulatory statutes permit a premium finance company to impose a delinquency charge. In some states where cancellation of the financed policy is regulated strictly, the finance company is permitted to make a cancellation charge, if the default results in cancellation of \$5. This is not in addition to the delinquency charge but serves to reimburse the finance company for the additional costs incurred by insureds who do not live up to their financial commitments. Most premium finance companies believe, and most regulators believe as well, that the insured who lives up to his financial commitments under a premium finance transaction should not be obliged to pay for the additional costs incurred due to the delinquent insured. By permitting delinquency fees and cancellation fees to premium finance companies, a premium finance company is in a position to render its services at a more reasonable cost to the insurance buying public. The theory of the delinquency charge is that the good payer does not have to pay for or support the bad payer. Afco operates on a nationwide basis. In states where we are not permitted to make a late or delinquency charge or indeed a cancellation charge, we are obliged to increase our overall rates somewhat to the insurance buying public because there is no other way to offset even partially the additional costs incurred in premium financing due to the delinquent insured.

#### Should Premium Financing Be Regulated

While it is true that some of the dozen or so state laws now in existence or actively under consideration regulating insurance premium financing were initiated as a result of overreaching and other abuses, the time has come when the public interest would be best served by having reasonably uniform premium financing legislation enacted in the various states. Relatively insignificant a decade or so ago, today premium financing is a billion dollar plus industry annually and as such is an important segment of the fire and casualty business. Thus, legislation on the subject which takes into account the interest of the public, insurance companies, agents and brokers and premium finance companies makes more and more sense with each passing year.

In addition to an adequate rate of charge for the financing service, the legislature assures itself that the method of cancellation of the financed policy will provide adequate protection to all parties concerned. Thus a good statute will require that the insured receives a 10 day notice of intent to cancel from the premium finance company if the default is not cured. A copy of this notice is usually required to be sent to the producer. This affords the delinquent insured an opportunity, if he wishes, to discuss the problem with his insurance agent. Because of the ever present delinquency problem most legislatures authorize a delinquency charge because most feel that the good citizen should not subsidize those which do not honor their financial commitments.

Because of the widespread use of premium financing today, it is an industry which should be regulated for the benefit of all concerned and there are a number of good laws which have been enacted which I can recommend to your committee. The Congress of the United States passed a law in 1966 which is applicable to the District of Columbia which has worked satisfactorily to all concerned, but more recently the State of Illinois has enacted a premium finance law which operates well. Similar is the Maryland law and a bill which is likely to be enacted in New Jersey shortly.

One of the dangers with the regulation is over-regulation. A regulator must be careful not to stifle the business because once the margin of profit to a premium finance company is reduced, it starts reducing its cost of operation by cutting corners in the service rendered and hiring less competent personnel. As a result the quality of the service rendered by the premium finance company is reduced and as a natural outgrowth, the problems for the regulator increase.

Substantial uniformity in the regulatory statutes and administration thereunder benefits the public by enabling the premium finance company to operate more efficiently.

## Who Should Regulate Premium Financing

Because premium financing involves an advancement of monies on behalf of the insured, which is the sole source of income to the premium finance company, one might think that the regulator in charge of licensed lenders, sales, finance companies and banks of all types should also regulate insurance premium financing. In our experience we do not think this is the best type of regulation because usually such a regulator is not conversant with insurance problems nor does he have any judicial or administrative power over the insurance carrier or the insurance producer nor does he know whether the insurance policy financed is an authorized policy. Even where the state regulator is in charge of both banks and insurance companies such offices quite often are departmentalized to such a degree that the employee of one department does not know the employee of the other department and even in such cases we would recommend that the Commissioner of Insurance or the Bureau of Insurance in the case where the regulator is in charge of both banks and insurance companies be the specific department to regulate insurance premium financing. The reason for this is because most premium financing problems do not concern themselves with the amount of the interest charged the public but concern themselves primarily with insurance problems, such as, was the cancellation of the financed insurance policy proper in the circumstances? Should the insurance company in the circumstances be required to remit the unearned or return premium to the premium finance company directly when a financed policy has been cancelled or should it remit the return premium through its agency channels? If the insurance company remits the unearned premium through agency channels, what are its responsibilities in the event the finance company does not receive the return premium? What is the responsibility of the premium finance company, insurance carrier, etc. when a fraud has been perpetrated? How should premium finance transactions be treated when the insurance carrier has become insolvent, is undergoing liquidation or rehabilitation, bearing in mind that the return premiums payable under the insurance policies represent the principal invested in the premium finance company by stockholders or banks? What policy should be adopted by the regulator to keep the insurance premium finance business a healthy business? Should not a regulator think of the thousands of insureds which may be prejudiced by permitting an insurance carrier to withdraw its operation from the state on a mere promise by the carrier that it will honor all of its commitments in the state and upon this promise, permit the carrier to withdraw those funds from the state which were required to be deposited in connection with its application to transact business in the state originally? These questions concern insurance. I think a poll of regulators of premium financing in the states today will disclose that the problems in connection with premium financing are intimately connected with the insurance industry and not with the rate of charge which the regulated premium finance company imposes for its services to the public because once the premium finance company is regulated in this regard, this is one area that the premium finance company is not likely to abuse for fear of losing its license.

We think it important that sufficient rapport is developed between a premium finance company and the insurance department so that a premium finance company can be made aware sufficiently in advance to prevent a large loss where the Insurance Department knows that the insurance carrier has an impairment of capital. Insurance Department personnel may also be aware that an insurance carrier is not in the hands of the proper type of management and in such cases a word to the wise is sufficient. Such advice would go a long way to prevent an extreme hardship to the insurance buying public.

In short a premium finance company is part of the entire insurance industry. It should be treated by the regulator not as an orphan but as a fully adopted child which should be protected just as much as the insurance buying public should be protected. When the premium finance company is not protected, it will ultimately work a hardship upon the public which the insurance department has a duty to protect.

Respectfully submitted,

S/d

Edward W. Horne

Portland, Oregon

June 17, 1968

**Michigan Report**  
**Premium Financing**

Premium financing is one means of spreading the payment of premiums over a period of time as opposed to full cash payment with the application. It is our experience in Michigan that premium payments, other than cash, can be accomplished by the following means:

- (1) Short term policies.
- (2) Short term renewable policies.
- (3) Annual policies with premiums paid directly to the insurance company at 3, 6, and 9 month intervals.
- (4) Cash payment to the insurance companies where money is borrowed from banks and other licensed lending institutions.
- (5) Credit card financing.
- (6) Financing through subsidiaries owned or controlled by insurance companies.
- (7) Premium loans by agents.
- (8) Check-O-Matic Plans.
- (9) Department store charge plans.
- (10) Insurance Premium Finance Companies.

**Short Term Policies**

Policies written for short terms, usually 3 months, were designed in part for insureds that could not pay annual premiums.

Obviously the underwriting expense of issuing new policies every three months cost insureds more than buying on an annual basis. Never the less this method did not give rise to complaints probably because it served the particular insureds needs and was cheaper than financing through other sources.

Short term policies are rapidly falling by the wayside and are being replaced by monthly, quarterly or semi-annual renewable policies.

**Short Term Renewable Policies**

Short term renewable policies also provide a means of payment on less than an annual basis and have the advantage of some reduction in underwriting expense in that new policies are not issued but the old ones simply continued in force by timely payment of premiums.

This method gave rise to two problems:

- (1) We found that some companies would accept a late payment and continue the policy in force without a lapse in coverage provided there was no claim between the expiration date and the receipt of the renewal premium. If there was a claim during this period the company would deny it and reinstate coverage effective on the date the renewable premium was received.
- (2) Companies were not issuing endorsements or new policy forms where there had been restrictions or liberalizations in coverage for considerable periods of time.

**Annual Policies with the Premium Paid at Quarterly Intervals**

This method of spreading out the premium payments has caused no problems. It is accomplished through rate filing, with a reasonable additional charge because of the increased clerical and accounting work involved and the loss of investment income. In every case the charges in excess of annual pay have been considerably less than the usuary statutes permit. However, the question arises as to whether or not it would be advisable to have the company reflect the assets for unpaid installments as a deduction from the liability for unearned premium rather than as an asset per se.

The inclusion of unpaid installments as an asset has a tendency to inflate the total admitted assets which in turn serve as a standard on which to compute provisions of the investment section of the Code.

Perhaps this item should be referred to the blanks committee.

#### Payment of Premiums with Money Borrowed from Licensed Lending Institutions

This is a business transaction divorced from the insurance industry provided there is no collateral assignment of the unearned premium. We have had no problems in this area.

#### Credit Card Financing

This is a relatively new method of premium payment. The Michigan Department reviews each one coming to our attention on its merits.

Our general position has been that if there are no features that violate our code it is permissible provided the net premium to the insurance company is not affected and the lending institution has no claim on the insurance company's unearned premium reserve.

#### Financing through subsidiary corporations owned or controlled by an insurance company or group of companies

The examination of any insurance company that owns or controls a premium finance company should, in our opinion, include a thorough review of the operation. Particular attention should be given to the source and amount of operating capital. If the insurance company provides the capital, is it an authorized investment? If insurance company officers or employees are furnishing the capital, is there a conflict of interest? If an employee divides his time in both corporations, is the expense properly apportioned?

If the premium finance company is under capitalized they may be working on say a 90 day float. The effect being they are executing new loan agreements and depending on timely collection of installments to pay the insurance company money they should have paid at the time the loan contract was executed. This suggests two potential problems (1) A significant increase in the number of loans in a short period of time could result in insufficient collections to meet the 90 day obligation to the insurance company and, (2) A lending entity begins earning interest upon execution of the agreement and should, for both legal and moral reasons, pay the amount borrowed to the insurance company at the same time. The insurance company in turn has the full premium for reserve and investment income purposes in a timely manner, as it should have.

#### Premium Loans by Agents

The Michigan Insurance Code is silent on this subject.

Upon inquiry from agents our general position (no formal ruling) has been that they should consult with counsel and be mindful of the usuary statutes. Also it may be advisable to execute a note at the time of sale, at the going legal interest rate to avoid a rebating violation, i.e. ". . . a valuable inducement to or for the sale of insurance not specified in the (insurance) contract . . ."

A very significant and old familiar problem frequently arises. The agents inability to collect his accounts—robbing Peter to pay company balances and operating expenses—violation of fiduciary trust—agency insolvency—company accounts over 90 days uncollected—company making good to policyholders after already giving credit on previous accounts current.

#### Check-O-Matic Plans

The variety of plans devised whereby an agent or company is authorized to negotiate an instrument at specified time intervals thereby reducing an insureds account balance has been a headache for the companies in many instances. Dishonored instruments, non-sufficient funds checks, premature publishing, etc., all lead to a strained relationship at best.

Since the number of complaints in this area have reduced substantially in the last 2 or 3 years we assume the companies are becoming disenchanted with this method of premium payment and seeking other means.

#### Department Store Charge Plans

This method of financing is particularly appealing to companies pioneering the mass marketing approach and to Department stores. The advantage to a company in soliciting a large group of people by mail or obtaining their names for leads is

obvious—the Department stores have learned that keeping a charge account active induces greater use of the account for purchase of other merchandise.

In Michigan a Department store is permitted to have two prices on their merchandise: cash price and time price. The time price is controlled only by competition and not subject to the usuary statutes. However, the Attorney General has ruled that insurance does not lend itself to the "time price" theory of financing because of the rate regulatory aspect.

The latest proposal before the Michigan Department is a Department store billing that shows the charge for insurance as a separate item not subject to time price.

#### Insurance Premium Finance Companies

Regulation of companies dealing exclusively in the financing of insurance premiums has been the subject of proposed legislation in Michigan for the past 4 years.

To our knowledge there are approximately 12 states that now have licensing and regulatory statutes. We also understand that approximately 15 other state legislatures considered similar bills in 1967.

The injustices to the public accomplished through some unregulated premium finance companies are numerous and flagrant.

The insureds appointment of the finance company as his attorney in fact for the purposes of cancellation and receipt of the unearned premium defeats the time tested method of cancellation which specifically advises the insured of the date his coverage ceases. The return of the unearned premium to the finance company is no guarantee that the insured will receive any overpayment. In some instances the finance companies have been known to continue to collect installments after cancellation.

Some other problems encountered are:

- (1) Interest rates ranging up to 45% not counting late charges, etc.
- (2) Non-signature loan agreements.
- (3) Finance company using unearned premiums on cancelled policies to offset agents balances without making an accounting and continuing to collect installments from the insured whose policies were cancelled.
- (4) Agents collecting the installment payments and not turning them over to the finance company. The finance company subsequently turning the account over to a collection agency.

From the public interest standpoint it appears that policies issued on an annual term with the premium payable to the company on a quarterly or semi-annual basis is desirable. However, in recent years investment income has substituted for underwriting losses in some lines of insurance and has prevented serious surplus drain.

Further we believe any attempt to prevent premium financing by any legitimate private enterprise is contrary to our economic system and would therefore be undesirable.

Under these circumstances we are at a loss to recommend an N.A.I.C. resolution or model bill. We do recommend a free and willing exchange of information between the states and that the problems be resolved by the individual states.

## Subcommittee to Study Regulations of Financial Guarantees (F8)

(Mtg. 19)

The Subcommittee to Study Regulations of Financial Guarantees met in Parlor C of the Portland Hilton Hotel on June 17, 1968. A quorum was present.

It is recommended that the Subcommittee obtain the technical advice of the Surety Association of America as to whether the particular contracts under consideration represent a unique or unusual type of surety obligation. We are requesting that the Surety Association of America make a report to this Subcommittee thirty days prior to the mid-winter 1968 meeting of the NAIC in Los Angeles, California.

It is recommended that the Association's advice be requested as to whether any special underwriting or other attention is required for such contracts.

Hon. Richard S. L. Roddis, Chm. by Edward Germann, Calif.; Hon. Lorne R. Worthington, Iowa; Hon. Elmer V. Omholt, Mont.; Hon. Edwin S. Lanier by Robert E. Holcombe, N. C.

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COMMISSIONER KNOWLTON: Mr. Chairman, I move that the report be received and, if there is no objection, it be adopted.

COMMISSIONER BARNES: Second.

PRESIDENT BENTLEY: You have heard the motion and the second by Commissioner Barnes of Colorado. Is there any objection to the adoption of this report? The Chair hears none and the report of the (F) Committee is adopted.



PRESIDENT BENTLEY: The next Report is the Valuation of Securities Committee report, Commissioner Parker, Chairman. Superintendent Stewart of New York is recognized, Vice Chairman of this Committee, to make the report.

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VALUATION OF SECURITIES (G) COMMITTEE

AGENDA - MTG. NO. 35

WEDNESDAY A.M.

JUNE 19, 1968

9:00 - 10:15

BALLROOM B

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Reference

1968 Proc. VOL. I pp 307-309

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1. Valuation of Securities (G1) Subcom. Report (Mtg. 20)

Meeting March 29, 1968 - New York, N. Y.

Hon. Richard E. Stewart, Chm., N. Y.

Hon. Joseph G. Wood, V. Chm., Ind.

Refs: 1967 Proc. VOL. II p 521 (additional references)

1967 Proc. VOL. II pp 529-578

1968 Proc. VOL. I pp 308-309

2. Any other matter submitted for consideration.

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VALUATION OF SECURITIES (G) COMMITTEE Report  
(Mtg. 35)

The Valuation of Securities Committee met at 9:00 a.m., June 19, 1968, in the Portland-Hilton Hotel, Portland, Oregon. A quorum was present.

Following a reading of the Audit Report prepared by Joseph Froggatt & Company, Inc., of the Committee's accounts as of May 31, 1968, a copy of which is attached hereto, the Committee voted to accept and approve said Report.

The Report of the Valuation of Securities Subcommittee, comprising the minutes of the Subcommittee Meeting of March 29, 1968, and June 17, 1968, was received by the Committee and was, upon motion duly made and seconded, adopted.

There being no further business to come before the Committee, the meeting was adjourned.

Hon. T. Nelson Parker, Chm., Va.; Hon. Richard E. Stewart, V.Chm., N. Y.; Hon. William R. Cotter, Conn.; Hon. Robert A. Short, Del.; Hon. Broward Williams, Fla.; Hon. James L. Bentley, Ga. by J. B. P.; Hon.

John R. Blaine, Idaho; Hon. John F. Bolton, Jr., Ill.; Hon. Joseph G. Wood, Ind.; Hon. Dudley A. Guglielmo, La.; Hon. C. Eugene Farnam, Mass.; Hon. Elmer V. Omholt, Mont.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Louis T. Mastos, Nev.; Hon. Charles R. Howell, N. J.; Hon. Eugene P. Brown, Ohio; Hon. Joe B. Hunt, Okla.; Hon. David O. Maxwell, Pa.; Hon. Ralph A. Petrarca, R. I.; Hon. Warren E. Dirks, S. D.; Hon. David M. Pack, Tenn.; Hon. Clay Cotten, Texas; Hon. Lee I. Kueckelhan, Wash.

JOSEPH FROGGATT & CO., INC.

Accountants and Auditors

Hon. T. Nelson Parker, Chairman  
Committee on Valuation of Securities  
of the National Association of Insurance Commissioners  
New York, New York

Dear Sir:

We have examined the attached balance sheet of the Committee on Valuation of Securities of the National Association of Insurance Commissioners at May 31, 1968 and the related statement of revenues and expenses and schedule of state contributions for the fiscal year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the statements and schedule referred to above present fairly the financial position of the Committee on Valuation of Securities of the National Association of Insurance Commissioners at May 31, 1968, arising from cash transactions, and revenues and expenses during the fiscal year then ended, on a basis consistent with that of the preceding year.

JOSEPH FROGGATT & CO., INC.

W. L. Hippard  
Vice President

New York, New York  
June 7, 1968

BALANCE SHEETS

	May 31,	
	1968	1967
<b>ASSETS</b>		
Cash in banks:		
Checking account -----	\$ 4,114.40	\$ 6,612.83
Savings accounts -----	136,245.63	126,181.80
	\$140,360.03	\$132,794.63
Petty cash fund -----	100.00	100.00
<b>Total -----</b>	<b>\$140,460.03</b>	<b>\$132,894.63</b>
<b>UNEXPENDED REVENUES</b>		
Balance, beginning of fiscal year -----	\$132,894.63	\$162,075.89
Revenues over (under) expenses_	7,565.40	(29,181.26)
<b>Balance, end of fiscal year -----</b>	<b>\$140,460.03</b>	<b>\$132,894.63</b>

## STATEMENT OF REVENUES AND EXPENSES

Fiscal Years Ended May 31,

	1968	1967	1968 Over (Under) 1967
<b>REVENUES</b>			
Assessments (Note 1) -----	\$ 80,022.40	\$ 80,037.78	\$ (15.38)
State contributions (Note 1) -----	15,614.58	15,599.58	15.00
Sale of Association Valuations -----	13,529.25	12,566.70	962.55
Sale of Book of Valuations -----	102,896.00	101,930.00	966.00
Interest on savings bank accounts -----	8,063.83	7,623.38	440.45
Postage-mailing charges -----	3,699.38	2,358.34	1,341.04
Sale of booklet "Valuation Procedures and Instructions for Bonds and Stocks" -----	134.68	163.20	(28.52)
<b>Total</b> -----	<b>223,960.12</b>	<b>220,278.98</b>	<b>3,681.14</b>
<b>EXPENSES</b>			
Audit -----	625.00	550.00	75.00
Electricity -----	1,541.25	1,649.64	(108.39)
Equipment and furniture (Note 2) -----	1,523.30	22,161.86	(20,638.56)
Equipment and furniture, maintenance -----	949.10	984.96	(35.86)
F.I.C.A. taxes -----	3,674.91	3,319.90	355.01
Hospitalization and group insurance premiums -----	6,144.65	4,573.52	1,571.13
Insurance -----	754.01	837.36	(83.35)
Legal fees -----	-0-	22,193.83	(22,193.83)
Miscellaneous -----	1,020.44	935.04	85.40
Moving and other relocation expense -----	-0-	953.41	(953.41)
Pension plan premium -----	5,254.35	5,750.94	(496.59)
Postage and mailing service -----	1,702.32	1,088.72	613.60
Printing and book production -----	23,590.20	23,129.15	461.05
Rent -----	22,515.62	19,549.83	2,965.79
Salaries -----	138,622.89	132,806.90	5,815.99
Stationery and supplies -----	2,054.20	3,118.57	(1,064.37)
Statistical service and books -----	2,360.00	2,254.41	105.59
Telephone and telegraph -----	2,795.04	2,810.01	(14.97)
Traveling -----	1,267.44	792.19	475.25
<b>Total</b> -----	<b>216,394.72</b>	<b>249,460.24</b>	<b>(33,065.52)</b>
<b>Revenues over (under) expenses</b> -----	<b>\$ 7,565.40</b>	<b>\$ (29,181.26)</b>	<b>\$36,746.66</b>

**SCHEDULE OF STATE CONTRIBUTIONS**  
 Received During the Fiscal Year Ended May 31, 1968

	Voluntary	Assessment
Alabama -----	\$ 200.00	
Alaska -----	-0-	
Arizona -----	200.00	
Arkansas -----	175.00	
California -----	1,000.00	
Colorado -----	175.00	
Connecticut -----	500.00	\$10,696.37
Delaware -----	100.00	
District of Columbia -----	75.00	
Florida -----	1,000.00	
Georgia -----	500.00	
Hawaii -----	75.00	
Idaho -----	250.00	
Illinois -----	-0-	
Indiana -----	600.00	
Iowa -----	-0-	
Kansas -----	81.25	
Kentucky -----	300.00	
Louisiana -----	375.00	
Maine -----	133.33	
Maryland -----	350.00	
Massachusetts -----	500.00	12,247.41
Michigan -----	300.00	
Minnesota -----	350.00	
Mississippi -----	150.00	
Missouri -----	300.00	
Montana -----	50.00	
Nebraska -----	300.00	1,383.56
Nevada -----	200.00	40.00
New Hampshire -----	100.00	
New Jersey -----	450.00	15,408.86
New Mexico -----	600.00	
New York -----	-0-	35,647.97
North Carolina -----	200.00	
North Dakota -----	100.00	
Ohio -----	-0-	1,657.45
Oklahoma -----	200.00	
Oregon -----	200.00	
Pennsylvania -----	1,250.00	2,940.78
Rhode Island -----	100.00	
South Carolina -----	125.00	
South Dakota -----	400.00	
Tennessee -----	500.00	
Texas -----	600.00	
Utah -----	150.00	
Vermont -----	300.00	
Virginia -----	500.00	
Washington -----	450.00	
West Virginia -----	150.00	
Wisconsin -----	500.00	
Wyoming -----	300.00	
Government of Guam -----	100.00	
Puerto Rico -----	100.00	
	<u>\$15,614.58</u>	<u>\$80,022.40</u>

## NOTES TO FINANCIAL STATEMENTS

May 31, 1968

## NOTE 1 - ASSESSMENTS AND CONTRIBUTIONS:

Assessments represent amounts levied against the States of Connecticut, Massachusetts, Nebraska, Nevada, New Jersey, New York, Ohio and Pennsylvania, based upon the admitted value of stocks and bonds of the life insurance companies in those States to maintain the operations of the Committee for the fiscal year ended May 31, 1968, which the States, in turn, collect from the life insurance companies on a pro rata basis. There were no assessments unpaid at May 31, 1968. Certain of these states also made voluntary contributions.

State contributions of \$15,614.58 are on a voluntary basis in accordance with Article 10 of the Constitution of the National Association of Insurance Commissioners.

## NOTE 2 - EQUIPMENT AND FURNITURE:

Equipment and furniture purchased are charged to expenses when paid. Asset balances are not established. Of the total amount paid in the fiscal year ended May 31, 1967, \$21,596.78 represented relocation and refurbishing the Committee's new offices at 60 Wall Street, New York City.

Valuation of Securities (G1) Subcom. Report  
(Mtg. 20)

The Valuation of Securities Subcommittee met on June 17, 1968, at 1:30 p.m. in the Hilton Hotel, Portland, Oregon.

Honorable Richard E. Stewart, Chairman, presided.

A quorum was present.

1. On motion duly made and seconded the Subcommittee voted to dispense with the reading and then unanimously approved the minutes of the March 29, 1968, Subcommittee meeting.
2. The staff report on the operation of the Mandatory Securities Valuation Reserve in 1967, previously discussed at the spring meeting of the Subcommittee, was received.
3. Following discussion of a request submitted by National Investors Life Insurance Company for reconsideration of the Subcommittee's 1967 decision to value that company's stock on a "book value" basis, the Subcommittee on motion duly made and seconded voted unanimously to deny the company's petition.
4. The Chairman noted that a request from Home Owners Insurance Company (Illinois) for consideration by the Subcommittee of a reclassification of the shares of federally insured savings and loan associations had been received too late to be placed on the agenda for the Portland meeting. The matter was held for consideration at the next Subcommittee meeting.

There being no further business before the Subcommittee the meeting was adjourned at 2:15 p.m.

Hon. Richard E. Stewart, Chm., N. Y.; Hon. Joseph G. Wood, V.Chm., Ind.; Hon. William R. Cotter, Conn.; Hon. Broward Williams, Fla.; Hon. John F. Bolton, Jr., Ill.; Hon. C. Eugene Farnam, Mass.; Hon. Benjamin C. Neff, Jr., Neb.; Hon. Louis T. Mastos, Nev.; Hon. Charles R. Howell, N. J.; Hon. Eugene P. Brown, Ohio; Hon. David O. Maxwell, Pa.; Hon. T. Nelson Parker, Va.

**Staff Report**

**Mandatory Securities Valuation Reserve**

Most companies in 1967 experienced large increases in their Mandatory Securities Valuation Reserves, due to a reversal in the stock market which created sizable capital gains in the Common Stock Reserve. While losses continued in the Bond and Preferred Stock Reserve Component, they were more than offset by the increase in the Common Stock Reserve Component.

A summary of the results of the 208 companies included in this year's study appears below (see Tabulation I, II, and III attached, for details on each company). The \$601 million in total additions to the Reserves was mostly due to unrealized gains on common stocks. Fluctuations due to the rise and fall of stock prices have a great impact on the Reserve each year since market prices are used for valuation purposes.

Bonds and preferred stock, for the most part, are valued at cost or amortized cost. However, losses on bonds in 1967 of \$140 million did no more than partially offset the \$552 million in realized and unrealized capital gains on common stocks. Bond prices showed sizable losses since interest rates continued at a very high level.

Since the elimination of the minimum reserve requirement in 1965, insurance companies may now charge losses to the full extent of their reserve. Of the 208 companies included in this survey, three companies ended the year with their Common Stock Reserves reduced to zero compared with 21 companies in 1966. Five Companies had their Bond and Preferred Stock Reserve at zero as against one company in 1966.

The Temporary Excess Reserve was almost exhausted by security losses in 1966. During 1967 insurance companies continued to charge losses to this Reserve. Companies are required to charge all losses to the Temporary Reserve until it is eliminated before making charges to the other reserve components. Of the 38 companies with balances in the Reserve at the beginning of 1967, only 26 had balances remaining at the end of the year.

Few companies had reserves at the maximum. Only 25 companies reached the maximum for the Bond and Preferred Stock Reserve compared with 26 companies the previous year. For the Common Stock Reserve, 57 companies reached the maximum compared with 21 at the end of 1966.

#### Summary of 208 Companies

(In Thousands)

	Bond & Preferred Stock Reserve	Common Stock Reserve	Temporary Excess Reserve	Total M. S. V. R.
12/31/66	\$1,197,771	\$1,149,037	\$62,571	\$2,409,379
Formula Additions	96,531	60,113		156,644
Net Capital Gains or Losses	(140,137)	552,139	(22,058)*	389,944
Voluntary Additions and Adjustments	49,523	4,905		54,428
<u>12/31/67</u>	<u>\$1,203,688</u>	<u>\$1,766,194</u>	<u>\$40,513</u>	<u>\$3,010,395</u>

\* Includes small voluntary charges allowable under Section 5C(c).

Further study was made of 28 major companies for the period 1951 through 1967. Chart I illustrates the progress of the total reserves of the 28 companies and compares it with the maximum limitation in each year. The maximum fluctuates with the magnitude of the bond and stock portfolios. Total bonds and stocks for the 28 companies reached \$65.8 billion, up from \$62.7 billion in 1966. Total common stock increased by \$941 million reaching \$4.6 billion in 1967 as compared with \$3.7 billion in 1966.

Chart II illustrates the trend in recent years of loans failing to meet the requirements of Test No. 1. The drop in 1965 on the chart was caused by a change in the Committee's standards for contingent interest bonds. Contingent interest bonds formerly automatically failed the Committee's Tests, but in 1965 the Committee's procedures were amended to permit passage of such bonds provided they met certain standards. The result was a reclassification of \$385 million from the 20% maximum reserve class to the 2% maximum reserve class for the 28 companies studied. If the totals were to be adjusted for this procedural change, it would show no decline in 1965 but an increase of 17%. In 1967, for the first time in eight years, the amount of bonds in the higher reserve (lower quality) category did not increase. In 1967 the amount of bonds in this category declined from \$1,650 million in 1966 to \$1,639 million.

#### Conclusion

It may be concluded from the results of this study that once again the reserves performed satisfactorily in 1967. The Staff recommends that no changes be made in the provisions governing the operation of the Mandatory Securities Valuation Reserve.

April 19, 1968

Chart I

Development of the Mandatory Securities  
Valuation Reserve for Twenty-eight  
Major U. S. Life Companies

1951 - 1967

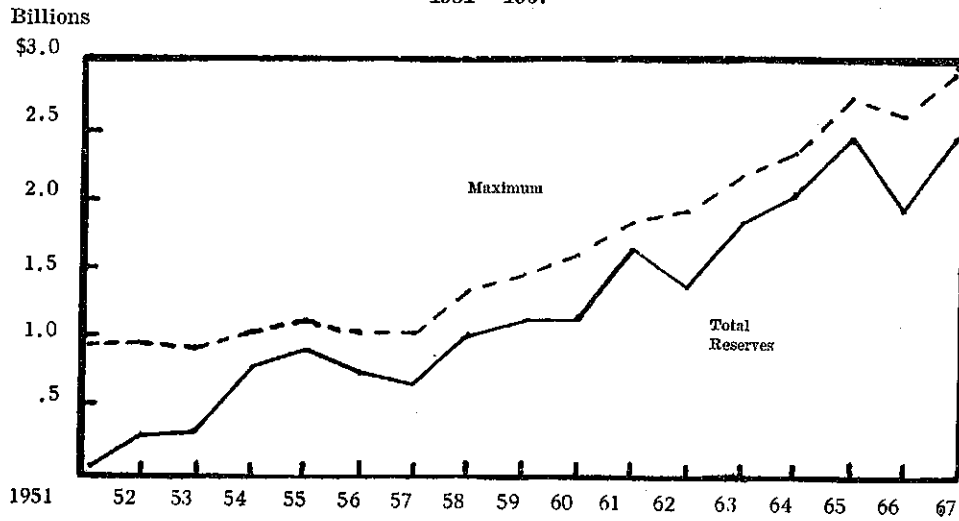
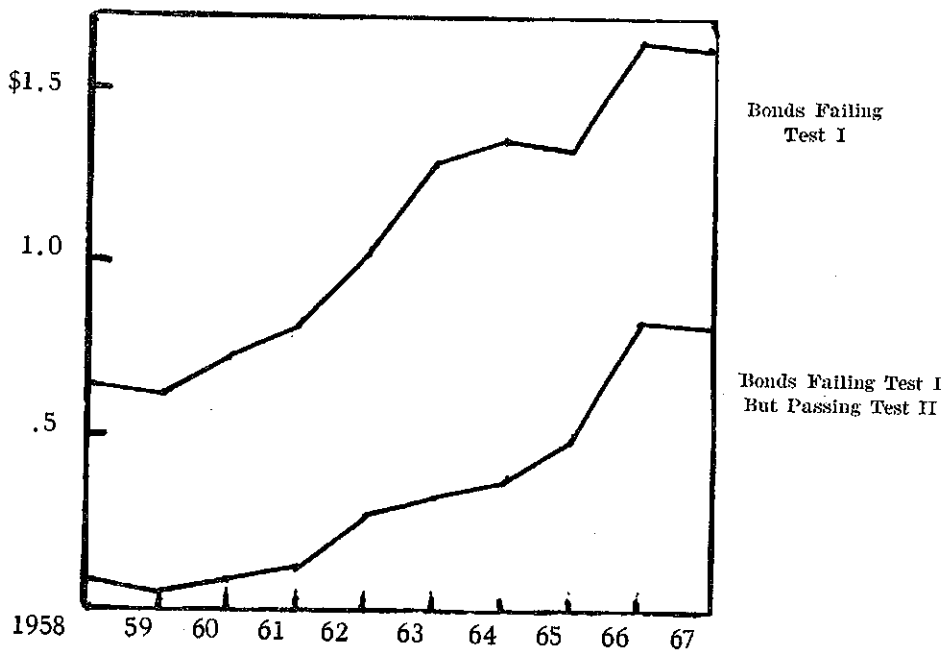


Chart II

Bonds Failing Test I for  
28 Major Life Insurance Companies

Billions





VALUATION OF SECURITIES COMMITTEE  
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

TABULATION OF DATA ON MANDATORY SECURITIES VALUATION RESERVE  
(BASED ON 1967 ANNUAL STATEMENT)

TABULATION I PAGE 1

NAME OF COMPANY	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
	Total Bonds (000)	Ratio of Total Bonds to Admitted Assets	Ratio U.S. Govt. Bonds to Total Bonds	Ratio Bonds in 2% Maximum Reserve Class to Total Bonds	Ratio Bonds in 10% Maximum Reserve Class to Total Bonds	Ratio Bonds in 20% Maximum Reserve Class to Total Bonds	Preferred Stocks (000)	Common Stocks (000)	Ratio Common Stocks To Total Admitted Assets	Total M.S.V.R. 12/31/66 (000)	Total M.S.V.R. 12/31/67 (000)
1. ACACIA MUT. LIFE INS. CO.	\$ 157,687	29.73%	21.58%	78.00%	0.32%	0.10%	\$ 2,006	\$ 6,680	1.30%	\$ 2,594	\$ 2,117
2. AETNA LIFE INS. CO.	2,980,856	47.41	3.66	94.13	1.16	1.05	56,528	131,077	4.42	33,863	50,942
3. AID ASSOC. FOR LUTHERANS	466,304	71.48	1.96	93.46	3.12	1.46	1,328	23,771	3.62	14,253	19,457
4. ALL AMER. LIFE & CAS. CO.	23,815	39.65	2.36	97.55	-	0.09	2,753	2,360	3.92	253	520
5. AMER.-AMICABLE LIFE INS.CO.	34,020	20.99	19.67	78.49	1.56	0.28	2,693	31,884	19.67	1,361	6,070
6. AMER. GEN. LIFE INS.CO.	45,490	25.11	1.31	92.84	4.84	1.01	-	1,377	0.76	148	371
7. AMER.GEN.LIFE INS.CO. DEL.	98,564	39.41	1.17	96.53	1.45	0.85	-	9,307	3.72	2,639	2,198
8. AMER.GEN.LIFE INS.CO. OKLA.	17,432	39.34	-	100.00	-	-	324	722	1.63	86	187
9. AMER.HEALTH & LIFE INS.CO.	60,118	79.50	14.40	85.60	-	-	424	9,436	12.48	960	1,624
10. AMER. HERITAGE LIFE INS.CO.	16,509	41.40	4.47	74.21	13.26	8.06	-	2,377	5.96	1,121	1,403
11. AMER. HOSP.& LIFE INS.CO.	3,047	12.08	15.86	83.79	-	0.35	1,194	1,557	6.17	163	340
12. AMER.LIFE & ACC.INS.CO. OF KY.	33,829	60.82	9.83	90.17	-	-	3,288	10,093	18.14	2,431	3,113
13. AMER.LIFE INS.CO. OF N.Y.	9,807	78.17	6.87	91.98	1.15	-	361	316	2.52	196	279
14. AMER. MUT. LIFE INS.CO.	57,618	55.66	6.16	93.84	-	-	2,552	252	0.24	1,055	1,242
15. AMER. NATIONAL LIFE CO.	484,621	38.73	3.20	88.37	2.00	6.43	31,016	97,432	7.79	26,558	38,550
16. AMER.SLOV.CATH.UNION (KSKJ)	12,188	70.63	12.47	87.25	-	0.28	516	-	-	234	242
17. AMER.UNITED LIFE INS.CO.	132,947	50.01	5.84	92.59	1.57	-	4,907	3,322	1.25	2,390	2,620
18. ATLAS LIFE INS.CO.	20,473	50.83	10.57	89.43	-	-	-	543	1.35	212	332
19. BALTIMORE LIFE INS.CO.	44,127	39.64	0.67	97.64	1.12	0.57	1,067	2,806	2.52	1,264	1,562
20. BANKERS LIFE & CAS. CO.	101,964	28.72	12.69	22.84	1.77	62.70	4,142	83,694	23.57	20,807	19,846
21. BANKERS LIFE CO.	616,927	36.53	6.41	92.20	1.29	0.10	7,637	57,780	0.03	11,302	15,752
22. BANKERS LIFE INS.CO.OF NEBR.	112,741	41.71	4.30	88.99	4.36	2.35	3,588	22,255	8.22	7,198	9,397
23. BANKERS NATL.LIFE INS.CO.	49,368	36.97	1.01	96.01	1.36	1.62	153	13,677	10.00	3,010	4,449
24. BEN HUR LIFE ASSOC.	15,941	77.42	5.47	94.01	-	0.52	405	-	-	345	337
25. BENEFICIAL LIFE INS.CO.	61,823	38.79	15.09	84.91	-	-	1,414	2,750	1.73	2,038	2,093
26. BENEFIT TRUST LIFE INS.CO.	20,086	35.92	17.18	82.82	-	-	10,293	5,317	9.51	2,700	2,756
27. BERKSHIRE LIFE INS.CO.	134,413	47.43	5.51	85.85	4.10	4.54	6,621	4,790	1.69	2,372	3,858
28. BOSTON MUT. LIFE INS.CO.	38,480	43.39	5.45	93.22	-	1.33	441	3,988	4.50	685	885
29. BUSINESS MEN'S ASSUR.CO.OF AMER.	97,034	30.00	10.77	88.60	0.30	0.33	3,075	9,451	2.96	1,650	2,005
30. CALIF.-WEST'N STATES LIFE INS.CO.	94,719	25.85	9.36	90.64	-	-	2,779	45,355	12.38	9,823	12,769
31. CENTRAL LIFE ASSUR. CO.	133,788	52.45	4.79	91.34	2.50	1.37	5,426	8,578	3.36	5,523	6,293
32. COASTAL STATES LIFE INS.CO.	32,008	45.67	17.45	82.55	-	-	1,120	7,773	11.09	419	1,008
33. COLLEGE LIFE INS.CO.OF AMER.	16,707	24.81	0.38	95.79	3.37	0.46	2,570	9,854	14.63	700	1,362
34. COLONIAL LIFE INS.CO.OF AMER.	70,252	45.16	4.99	94.24	0.46	0.31	457	438	0.28	450	533
35. COLUMBIAN MUT.LIFE INS.CO.	13,167	50.62	12.51	87.49	-	-	26	63	0.24	103	124
36. COLUMBUS MUT.LIFE INS.CO.	91,879	42.43	20.40	79.60	-	-	558	6,565	3.03	1,353	1,586
37. COMMONWEALTH LIFE INS.CO.	148,327	40.29	6.40	92.54	0.58	0.48	3,325	10,251	2.78	1,700	2,697
38. COMPANION LIFE INS.CO.	13,121	70.47	26.89	73.11	-	-	-	358	1.92	88	117
39. CONN.GEN.LIFE INS.CO.	1,874,729	66.48	6.64	89.94	1.66	1.76	14,790	102,812	2.55	41,247	54,730
40. CONN.MUT.LIFE INS.CO.	739,818	31.33	3.57	92.52	0.96	2.95	86,160	174,555	7.39	83,955	85,271
41. CONSTITUTION LIFE INS.CO.	27,815	65.75	69.90	23.98	0.38	5.74	325	3,536	8.36	1,131	700
42. CONTINENTAL AMER.LIFE INS.CO.	55,604	35.55	19.48	80.52	-	-	5,254	1,496	0.96	1,295	1,371
43. CONTINENTAL ASSUR. CO.	565,643	40.21	3.71	90.72	2.88	2.69	144	112,008	8.00	37,153	55,163
44. COUNTRY LIFE INS.CO.	133,112	36.54	3.61	92.92	2.36	1.11	10,722	15,578	4.28	4,541	5,734
45. CZECHOSLOVAK SOC. OF AMER.	8,987	39.55	27.32	67.87	2.20	2.61	14,600	-	-	180	183
46. DURHAM LIFE INS. CO.	27,856	22.72	33.79	65.81	-	0.40	984	16,246	13.25	395	426
47. EASTERN LIFE INS.CO. OF N.Y.	18,321	52.12	0.10	98.51	1.36	0.03	628	1,225	3.49	249	374
48. EQUITABLE LIFE ASSUR. SOC.	5,229,997	39.94	4.17	93.61	1.23	0.99	192,000	416,000	3.17	200,729	261,404
49. EQUITABLE LIFE INS.CO.	53,464	31.76	1.76	97.40	0.84	-	203	1,387	0.82	622	712
50. EQUITABLE LIFE INS.CO.OF IOWA	345,140	40.37	8.25	90.86	0.50	0.39	14,092	-	-	6,653	6,377

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(1) NAME OF COMPANY	(2) Total Bonds (000)	(3) Ratio of Total Bonds to Assets	(4) Ratio of U.S. Govt. Bonds to Total Bonds	(5) Ratio of Reserve Class to Total Bonds	(6) Ratio of Reserve Class to Total Bonds	(7) Preferred Stocks (000)	(8) Common Stocks (000)	(9) Ratio of Common Stocks to Total Admitted Assets	(10) Total M.S.V.R. 12/31/66 (000)	(11) Total M.S.V.R. 12/31/67 (000)	
											Total Bonds (000)
51. EQUITABLE RESERVE ASSOC.	\$ 10,925	47.95%	4.44%	93.98%	-	1.58%	\$ 236	\$ 1,074	4.71%	\$ 467	\$ 611
52. FARM BUR. LIFE INS.CO.	63,986	51.65	7.85	85.92	3.60	2.63	1,182	1,919	1.55	712	1,071
53. FARM FAMILY LIFE INS.CO.	16,975	49.21	5.19	93.65	0.65	0.51	1,315	198	0.57	38	128
54. FARMERS & BANKERS LIFE INS.CO.	14,451	23.52	17.46	82.36	-	0.18	831	2,674	4.35	635	906
55. FARMERS NEW WORLD LIFE INS.CO.	30,161	25.67	-	100.00	-	-	885	23,088	19.65	1,294	1,960
56. FARMERS & TRADERS LIFE INS.CO.	35,579	49.41	2.59	97.41	-	-	939	452	0.63	663	640
57. FEDERAL LIFE & CAS. CO.	14,697	32.49	20.75	79.25	-	-	200	1,119	2.47	104	182
58. FIDELITY LIFE ASSOC.	33,397	65.20	3.49	95.76	0.75	-	828	-	-	315	350
59. FEDERAL LIFE INS.CO.	25,222	40.65	13.61	85.50	-	0.89	214	-	-	248	277
60. FIDELITY MUTUAL LIFE INS.CO.	239,885	47.07	4.59	89.62	3.12	2.67	6,733	10,699	2.10	4,461	6,655
61. FRANKLIN LIFE INS. CO.	513,208	50.13	11.06	88.92	-	0.02	19,682	12,432	1.21	4,026	4,695
62. GEN. AMER. LIFE INS.CO.	123,910	28.65	7.29	90.91	1.51	0.29	8,173	12,356	2.86	1,571	2,804
63. GIRARD LIFE INS.CO.	5,633	10.89	16.00	84.00	-	-	-	2,095	4.05	129	209
64. GOLDEN STATE MUT. LIFE INS.CO.	9,775	33.80	3.09	96.91	-	-	258	595	2.06	152	221
65. GOVT. EMP. LIFE INS.CO.	13,759	30.41	87.48	12.52	-	-	7,252	878	1.94	278	298
66. GREAT NATL. LIFE INS.CO.	14,362	23.70	25.56	73.74	0.70	-	145	197	0.32	218	246
67. GREAT SOUTHERN LIFE INS.CO.	62,979	20.60	37.62	60.15	-	2.23	1,511	14,798	4.84	3,935	4,878
68. GREEK CATH. UNION OF U.S.A.	20,981	88.72	5.00	93.05	0.28	1.67	-	-	-	404	437
69. GUARANTEE MUT. LIFE CO.	75,061	40.96	8.03	86.45	3.25	2.27	1,462	967	0.53	1,936	933
70. GUARDIAN LIFE INS.CO. OF AMER.	276,411	35.39	1.67	93.34	3.54	1.45	6,201	3,339	0.43	6,224	6,113
71. HARTFORD LIFE INS.CO.	73,727	40.77	7.97	91.27	0.68	0.08	160	10,427	5.77	3,585	4,122
72. HOME BENEFICIAL LIFE INS.CO.	120,155	45.38	10.86	89.12	-	0.02	8	3,383	0.86	1,984	2,238
73. HOME LIFE INS.CO.	289,405	43.29	4.00	87.23	4.65	4.12	17,298	2,051	0.31	4,861	5,688
74. HOME LIFE INS.CO. OF AMER.	47,214	46.00	1.52	97.62	0.86	-	549	547	0.53	755	890
75. HOME SECURITY LIFE INS.CO.	22,690	39.39	11.82	88.18	-	-	2,531	4,721	7.21	1,315	1,784
76. INDEPENDENCE LIFE & ACC. INS.CO.	9,455	64.07	61.88	37.54	-	0.58	275	1,078	7.30	61	144
77. INDEPENDENT LIFE & ACC. INS.CO.	100,091	48.50	1.69	96.53	1.09	0.69	3,257	9,955	4.82	521	31
78. INDIANAPOLIS LIFE INS.CO.	88,670	45.14	3.32	94.76	1.86	0.06	843	1,931	0.98	1,215	1,437
79. INTERSTATE LIFE & ACC. INS.CO.	43,674	28.30	1.65	96.55	1.15	0.65	3,305	8,020	5.20	1,691	2,415
80. JEFFERSON NATL. LIFE INS.CO.	26,046	49.68	10.98	88.34	0.19	0.49	1,305	3,461	6.60	1,038	1,529
81. JEFFERSON STAND. LIFE INS.	286,214	32.15	5.97	91.03	2.24	0.76	18,355	82,459	9.26	25,273	31,971
82. JOHN HANCOCK MUT. LIFE INS.CO.	4,278,228	48.26	3.50	94.33	1.14	1.03	77,869	478,925	5.40	178,719	230,729
83. KANSAS CITY LIFE INS.CO.	151,174	30.08	16.41	83.59	-	-	3,491	2,331	0.46	2,499	2,770
84. KANSAS FARM LIFE INS.CO. INC.	12,124	48.07	5.55	93.96	0.08	0.41	471	511	1.99	207	285
85. KENTUCKY HOME MUT. LIFE INS.CO.	9,619	41.26	32.30	67.70	-	-	1,842	1,736	7.44	642	799
86. LAFAYETTE LIFE INS.CO.	27,573	40.57	3.71	96.29	-	-	253	2,337	3.44	792	1,068
87. LAMAR LIFE INS.CO.	27,067	23.81	-	92.16	3.74	4.10	2,740	10,055	8.85	517	2,392
88. LIBERTY LIFE INS.CO.	74,476	32.90	1.70	95.72	2.41	0.17	7,940	16,785	7.41	4,035	6,288
89. LIBERTY NATL. LIFE INS.CO.	186,607	29.69	38.66	60.98	0.36	-	-	841	0.13	2,772	3,073
90. LIFE & CAS. INS.CO. OF TENN.	145,455	31.39	1.95	92.35	4.23	1.47	21,796	50,181	10.83	7,897	16,063
91. LIFE INS. CO. OF GEORGIA	111,472	31.03	5.61	94.39	-	-	5,720	18,170	5.06	5,668	6,776
92. LIFE INS.CO. OF NO. AMER.	63,183	63.84	0.78	99.22	-	-	660	2,378	2.40	515	573
93. LIFE INS.CO. OF VIRGINIA	289,162	38.30	2.52	93.98	2.03	1.47	24,591	36,256	4.80	14,367	14,809
94. LINCOLN LIBERTY LIFE INS.CO.	14,156	21.14	2.47	93.98	2.58	0.97	542	5,452	8.14	1,507	2,086
95. LINCOLN MUT. LIFE INS.CO.	9,313	55.16	8.78	91.02	-	0.20	210	297	1.76	183	208
96. LINCOLN NATL. LIFE INS.CO.	862,262	41.25	4.38	92.00	2.46	1.16	159,398	240,582	11.51	69,826	88,283
97. LOYAL PROTECTIVE LIFE INS.CO.	24,106	42.25	2.69	97.10	0.21	-	2,577	4,184	7.33	1,569	1,997
98. LUTHERAN BROTHERHOOD	148,613	35.22	1.60	97.41	0.95	0.04	599	20,577	4.88	1,697	4,010
99. LUTHERAN MUT. LIFE INS.CO.	70,432	31.57	5.27	93.66	0.39	0.68	3,681	2,515	1.13	528	901
100. MACCABEES MUT. LIFE INS.CO.	75,315	46.20	6.12	92.63	1.11	0.14	851	6,327	3.88	1,525	2,109
101. MASS. INDEM. & LIFE INS.CO.	38,322	79.66	2.53	97.47	-	-	102	1,611	3.34	15	303
102. MASS. MUT. LIFE INS.CO.	1,657,389	45.08	0.32	92.31	3.97	3.40	77,147	167,743	4.56	82,666	108,501
103. METROPOLITAN LIFE INS.CO.	12,496,384	54.17	6.17	92.68	0.01	1.14	146,421	170,111	0.69	173,472	199,366
104. MICHIGAN LIFE INS.CO.	13,834	42.70	9.31	90.56	-	0.13	18	1,116	3.45	308	412
105. MIDLAND NA LIFE INS.CO.	26,725	49.58	5.85	91.76	1.78	0.61	1,458	4,904	9.10	1,924	2,001

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(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	
NAME OF COMPANY	Total Bonds (000)	Ratio of Total Bonds to Total Admitted Assets	Ratio U.S.Govt. Bonds to Total Bonds	Ratio Bonds in 2% Maximum Reserve Class to Total Bonds	Ratio Bonds in 10% Maximum Reserve Class to Total Bonds	Ratio Bonds in 20% Maximum Reserve Class to Total Bonds	Preferred Stocks (000)	Common Stocks (000)	Ratio Common Stocks To Total Admitted Assets	Total M.S.V.R. 12/31/66 (000)	Total M.S.V.R. 12/31/67 (000)
106. MIDWEST'N UNITED LIFE INS.CO.	\$ 37,249	41.27%	2.06%	95.08%	0.49%	2.37%	\$ 13	\$ 4,926	5.46%	\$ 1,288	\$ 1,833
107. MINISTERS LIFE & CAS.UNION	20,578	54.00	1.68	87.55	2.62	8.15	74	6,339	16.76	1,431	2,543
108. MINNESOTA MUT.LIFE INS.CO.	148,713	29.68	0.25	99.17	-	0.58	-	38,989	7.78	8,241	8,155
109. MISSOURI FIDELITY UNION TR.LIFE	10,242	68.84	15.87	82.47	-	1.66	210	470	3.16	128	234
110. MODERN WOODMEN OF AMER.	148,315	56.19	1.14	95.18	2.09	1.59	5,833	16,427	6.22	10,901	10,689
111. MONUMENTAL LIFE INS.CO.	117,476	32.76	8.12	91.13	0.51	0.24	13,903	13,695	3.82	5,107	6,473
112. MUT. BENEFIT LIFE INS.CO.	701,398	30.46	4.75	94.10	0.27	0.88	55,033	42,764	1.83	19,450	24,200
113. MUT.LIFE INS.CO. OF N.Y.	1,697,137	49.52	2.16	91.54	3.11	3.19	146,662	146,466	4.27	88,143	101,629
114. MUT.SAVINGS LIFE INS.CO.	15,569	34.98	7.05	91.53	-	1.42	-	2,487	5.59	211	238
115. MUT.SERVICE LIFE INS.CO.	17,892	39.71	-	94.60	0.28	5.12	215	563	1.07	258	326
116. MUT.TRUST LIFE INS.CO.	140,164	51.96	11.29	85.87	1.25	1.59	5,312	4,052	1.50	3,120	3,173
117. NATL. FIDELITY LIFE INS.CO.	16,201	34.11	-	100.00	-	-	3,393	-	-	195	235
118. NATL. GUARDIAN LIFE INS.CO.	39,324	39.79	4.55	95.38	-	0.07	-	732	0.74	516	664
119. NATL.LIFE & ACC. INS.CO.	658,089	44.56	2.48	97.52	-	-	98,597	99,057	3.61	24,253	29,077
120. NATIONAL LIFE INS. CO.	334,744	26.85	1.64	97.50	0.11	0.75	13,530	10,712	0.86	5,127	7,098
121. NATL. OLD LINE INS.CO.	37,930	37.48	6.67	91.43	-	1.90	1,401	2,846	2.81	682	691
122. NATL. PUBLIC SERVICE INS.CO.	14,583	35.64	6.22	93.74	-	0.04	231	34	0.08	263	297
123. NATL. RESERVE LIFE INS.CO.	38,718	38.33	2.85	97.15	-	-	296	1,841	1.82	734	1,036
124. NATL. STANDARD LIFE INS.CO.	4,786	45.38	9.57	88.96	1.06	0.41	37	233	2.21	143	159
125. NATL. TRAVELERS LIFE CO.	18,459	39.03	1.79	94.93	1.63	1.65	302	7	0.01	182	170
126. NATL. WEST'N LIFE INS.CO.	20,988	25.70	-	93.72	2.80	3.48	411	3,082	3.73	209	594
127. NATIONWIDE LIFE INS.CO.	147,694	41.90	3.59	93.74	2.02	0.65	9,602	10,711	3.04	4,707	6,934
128. NEW ENG. MUT.LIFE INS.CO.	1,313,825	41.75	2.40	96.78	0.22	0.60	99,436	139,064	4.42	64,634	66,256
129. NEW YORK LIFE INS.CO.	4,653,419	48.58	2.79	95.86	0.50	0.80	329,885	340,704	3.56	182,246	220,924
130. NO. AMER.BENEFIT ASSOC.	49,059	65.24	1.67	96.09	-	2.24	1,848	1,068	1.34	1,991	2,014
131. NO. AMER.CO.FOR LIFE & HEALTH	82,573	68.16	25.08	74.76	-	0.16	4,510	23,106	19.07	4,349	7,220
132. NO. AMER. LIFE & CAS. CO.	21,781	19.52	3.63	93.65	0.18	2.34	2,348	3,268	2.93	829	983
133. NO.AMER.LIFE INS.CO. OF CHIC.	23,494	29.33	5.81	91.32	1.68	1.19	1,377	3,670	4.58	1,300	1,661
134. NO.AMER. REASSURANCE CO.	54,580	62.35	24.47	73.88	0.82	0.83	7,620	1,837	2.09	2,159	2,098
135. NORTHERN LIFE INS.CO.	46,726	37.60	3.70	96.30	-	-	2,861	6,162	4.96	2,324	2,652
136. NORTHWEST'N MUT.LIFE INS.CO.	2,272,357	41.50	7.28	91.16	0.71	0.85	186,015	180,638	3.30	91,903	116,954
137. NORTHWEST'N NATL. LIFE INS.CO.	230,454	41.56	1.52	87.42	5.75	5.31	7,633	51,628	9.20	12,549	24,115
138. OCCIDENTAL LIFE INS.CO. CALIF.	504,178	36.23	6.09	89.63	0.29	3.99	9,717	90,365	6.49	41,507	45,848
139. OCCIDENTAL LIFE INS.CO. N.C.	26,618	37.01	13.00	85.13	1.03	0.80	162	3,338	4.64	1,107	957
140. OHIO NATL. LIFE INS.CO.	129,117	39.82	1.41	97.18	0.41	1.00	3,409	4,623	1.43	2,377	2,551
141. OHIO STATE LIFE INS.CO.	64,343	39.21	4.76	95.24	-	-	-	4,420	2.69	1,067	1,211
142. OLD AMERICAN INS.CO.	18,988	56.27	5.03	94.97	-	-	700	1,325	3.92	303	492
143. OLD LINE LIFE INS.CO.OP AMER.	30,972	34.84	6.31	93.53	0.16	-	-	1,181	1.77	667	685
144. PACIFIC MUT.LIFE INS.CO.	298,876	36.91	0.26	98.42	0.71	0.61	1,135	21,766	2.69	5,346	7,065
145. PACIFIC NATL.LIFE ASSUR.CO.	30,475	44.73	7.68	92.32	-	-	-	3,804	5.58	963	1,466
146. PAN-AMER. LIFE INS.CO.	133,040	41.30	2.98	94.35	1.02	1.65	4,803	12,548	3.89	2,736	3,704
147. PAUL REVERE LIFE INS.CO.	120,254	28.86	0.39	74.33	14.53	10.75	31,933	56,834	13.64	19,413	22,082
148. PENN MUT.LIFE INS.CO.	969,846	42.71	3.95	93.05	1.24	1.76	95,305	54,855	2.42	25,757	30,040
149. PENN. LIFE INS.CO.	19,396	50.24	9.14	88.69	-	2.17	815	1,566	4.06	138	328
150. PEOPLES-HOME LIFE INS.CO. IND.	16,249	29.51	6.02	93.98	-	-	-	-	-	185	203
151. PEOPLES LIFE INS.CO. WASH.D.C.	77,146	41.68	1.64	97.71	0.65	-	1,031	1,713	0.81	898	1,072
152. PHILA. LIFE INS.CO.	62,165	41.93	4.89	91.24	1.59	2.28	1,196	16,692	11.26	1,966	3,903
153. PHILANTHROPIC MUT.LIFE INS.CO.	5,470	70.24	15.90	83.82	-	0.28	442	77	0.99	168	143
154. PHOENIX MUT. LIFE INS.CO.	440,435	35.64	4.00	94.30	0.67	1.03	24,084	37,220	3.01	14,471	17,074
155. PIEDMONT SOUTH'N LIFE INS.CO.	7,628	9.61	21.94	75.31	2.62	0.13	22	46,649	58.76	11,417	15,498
156. PILOT LIFE INS.CO.	103,762	29.74	1.16	96.58	0.34	1.92	60	18,230	5.23	8,475	9,183
157. POLISH WOMEN'S ALLIANCE OF AMER.	26,385	97.11	10.59	87.28	-	2.13	-	-	-	212	276
158. PRESBYTERIAN MINISTERS' FUND	60,638	55.46	5.38	93.88	0.33	0.41	1,447	6,107	5.59	1,442	2,467
159. PROGRESSIVE LIFE INS.CO.	9,523	60.87	6.11	93.89	-	-	-	88	0.56	80	107
160. PROTECTIVE LIFE INS.CO.	43,556	27.41	11.48	87.60	0.92	-	2,629	8,533	5.37	2,427	3,300

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PROCEEDINGS - 1968 VOL. II

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	
NAME OF COMPANY	Total Bonds (000)	Ratio of Total Bonds to Total Admitted Assets	Ratio U.S. Govt. Bonds to Total Bonds	Ratio Bonds in 2% Maximum Reserve Class to Total Bonds	Ratio Bonds in 10% Maximum Reserve Class to Total Bonds	Ratio Bonds in 20% Maximum Reserve Class to Total Bonds	Preferred Stocks (000)	Common Stocks (000)	Ratio Common Stocks To Total Admitted Assets	Total M.S.V.R. 12/31/66 (000)	Total M.S.V.R. 12/31/67 (000)
161. PROVIDENT LIFE INS.CO.	\$ 39,807	49.40%	6.88%	93.03%	-	0.09%	\$ 16	\$ 9,445	11.72%	\$ 2,355	\$ 3,479
162. PROVIDENT LIFE & ACC.INS.CO.	136,647	29.66	3.34	95.47	0.06	0.13	43,634	5,611	1.22	4,878	4,973
163. PROVIDENT MUT. LIFE INS.CO.	484,013	43.25	6.32	92.32	1.10	0.26	35,193	40,747	3.81	19,073	20,266
164. PRUDENTIAL INS. CO. OF AMER.	10,209,935	40.66	3.75	91.85	2.95	1.45	97,722	1,106,138	4.40	365,789	475,467
165. PURITAN INS. CO.	13,357	80.65	2.19	96.37	1.20	0.24	28	-	-	128	139
166. RELIANCE STAND. LIFE INS.CO.	78,993	62.79	11.00	88.65	0.13	0.22	1,174	15,313	12.17	2,317	4,010
167. REPUBLIC NATL. LIFE INS.CO.	61,303	26.85	36.19	56.73	1.06	6.02	811	1,192	0.52	1,435	1,432
168. ROCKFORD LIFE INS.CO.	20,820	55.56	26.44	72.83	-	0.73	227	189	0.50	328	322
169. ROYAL NEIGHBORS OF AMER.	80,932	38.35	4.57	92.57	2.38	0.48	4,975	2,740	1.30	3,253	3,309
170. SAFECO LIFE INS.CO.	20,925	56.85	5.27	94.73	-	-	2,034	-	-	367	385
171. SECURITY BENE. LIFE INS.CO.	46,640	36.76	1.28	97.11	0.32	1.29	5,694	5,082	4.00	2,517	2,568
172. SECURITY MUT. LIFE INS.CO. NEBR.	22,298	35.47	6.79	93.21	-	-	26	471	0.75	328	309
173. SECURITY MUT. LIFE INS.CO. N.Y.	64,271	42.70	4.18	92.43	1.57	1.82	4,182	75	0.05	1,300	1,325
174. SENTRY LIFE INS.CO.	19,228	49.86	5.29	93.31	0.41	0.99	125	2,431	6.30	126	593
175. SHENANDOAH LIFE INS.CO.	28,362	30.90	5.25	93.09	0.16	1.50	766	3,202	3.49	806	1,103
176. SOUTHCOAST LIFE INS.CO.	12,562	22.75	29.50	67.63	1.12	1.45	131	499	0.90	239	265
177. SOUTHERN LIFE INS.CO.	10,020	18.64	-	99.30	-	0.70	309	7,092	13.20	73	89
178. SOUTHLAND LIFE INS.CO.	129,031	29.60	7.22	88.04	3.92	0.82	2,845	21,323	4.90	1,868	707
179. SOUTHWEST'N LIFE INS.CO.	257,654	28.77	19.21	80.66	0.04	0.09	22,166	50,501	5.64	14,260	15,641
180. STANDARD INSURANCE CO.	25,918	18.22	-	98.13	0.89	0.98	3,109	3,349	2.35	775	1,212
181. STANDARD LIFE ASSOC.	9,888	77.18	7.06	92.43	-	0.51	-	47	0.37	144	145
182. STAND. LIFE INS.CO. IND.	39,070	65.29	6.15	93.85	-	-	118	822	13.74	308	404
183. STATE FARM INS.CO.	231,574	43.82	15.07	82.20	1.47	1.26	21,020	12,426	2.35	7,257	8,280
184. STATE LIFE INS.CO.	46,910	45.77	23.76	76.24	-	-	-	-	-	371	405
185. STATE MUT. LIFE INS.CO. AMER.	452,591	41.60	0.17	82.97	8.81	8.05	18,032	87,336	8.03	28,608	44,530
186. SUN LIFE INS.CO. OF AMER.	61,489	34.78	0.94	95.61	1.73	1.72	31	12,128	6.86	4,771	5,227
187. SUNSET LIFE INS.CO.	22,932	60.86	5.84	93.87	0.17	0.12	-	1,499	3.98	522	596
188. TEACHERS INS. & ANN. ASSOC. AMER.	605,423	37.76	0.56	95.63	1.62	2.19	2,070	37,828	2.36	12,230	22,220
189. TENNESSEE LIFE INS.CO.	39,458	43.61	-	99.99	-	0.01	2,432	1,675	1.80	371	472
190. TRAVELERS INS.CO.	1,702,001	41.04	17.90	79.58	0.93	1.59	32,452	80,604	1.94	41,067	41,933
191. UNION CENTRAL LIFE INS.CO.	422,566	47.98	2.80	96.41	0.64	0.15	-	3,182	0.36	2,530	3,559
192. UNION LABOR LIFE INS.CO.	30,200	40.45	1.84	98.07	0.08	0.01	1,586	-	-	550	630
193. UNION MUT. LIFE INS.CO.	92,763	44.04	6.57	91.51	0.97	0.95	601	6,649	3.16	2,012	2,781
194. UNITED BENE. LIFE INS.CO.	235,812	40.53	10.00	89.31	0.64	0.05	36,671	35,848	6.16	14,765	17,049
195. UNITED COMM. TRAV. OF AMER.	11,884	93.64	13.65	86.35	-	-	-	-	-	93	101
196. UNITED FARM BUR. FAM. LIFE INS.CO.	45,044	49.66	3.47	95.97	0.56	-	3,100	2,192	2.42	1,530	1,795
197. UNITED INSURANCE CO. OF AMER.	98,367	29.80	3.40	95.54	0.31	0.75	19,716	11,268	3.41	1,237	1,823
198. UNITED LIFE & ACC.INS.CO.	18,961	24.21	1.04	98.96	-	-	615	1,180	1.51	244	417
199. UNITY MUT. LIFE INS.CO. N.Y.	25,264	63.14	43.61	56.39	-	-	39	10	0.03	210	229
200. VICTORY LIFE INS.CO.	41,768	63.83	11.75	87.55	0.12	0.58	568	2,283	3.49	392	423
201. VOLUNTEER STATE LIFE INS.CO.	32,251	28.99	6.63	93.37	-	-	122	2,932	2.64	729	1,078
202. WEST COAST LIFE INS.CO.	39,876	32.99	4.23	95.75	-	0.02	-	-	-	304	341
203. WESTERN LIFE INS.CO.	77,652	46.97	1.68	95.95	1.29	1.08	-	8,494	5.14	2,361	4,249
204. WEST'N & SOUTH'N LIFE INS.CO.	341,832	21.32	35.38	64.36	0.26	-	-	1,069	0.07	3,892	3,885
205. WESTERN STATES LIFE INS.CO.	16,539	45.36	3.33	95.44	0.79	0.44	-	932	2.55	308	524
206. WM. PENN. FRAT. ASSOC.	27,855	86.50	1.93	97.03	0.68	0.36	653	380	1.18	793	780
207. WISCONSIN NATL. LIFE INS.CO.	23,404	40.51	8.29	88.51	1.82	1.38	972	580	1.00	359	437
208. WOODMEN OF THE WORLD LIFE INS.CO.	199,070	56.19	11.37	86.14	0.42	2.07	1,776	20,007	5.64	10,455	11,095
TOTALS FOR 208 COMPANIES	\$70,550,005						\$2,697,552	\$6,092,505		\$2,409,379	\$3,010,395

(In Thousands)	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)
	BOND AND PREFERRED		STOCK	RESERVE	COMPONENT	Ratio B. & P.S. Reserve To Maximum	COMMON STOCK		RESERVE	COMPONENT	Common Stock Reserve 12/31/67	Common Stock Reserve To Maximum
	B. & P.S. Reserve 12/31/66	Formula Additions	Capital Gains or Losses	Voluntary Additions & Adjustments	B. & P.S. Reserve 12/31/67		Common Stock Reserve 12/31/66	Formula Additions	Capital Gains or Losses	Voluntary Additions & Adjustments		
NAME OF COMPANY												
1. ACACIA MUT. LIFE INS. CO.	1,259	\$ 133	\$ 51	\$ -	\$ 1,443	55%	\$ 1,231	\$ 66	\$ (570)	\$ -	\$ 727	33%
2. AETNA LIFE INS. CO.	31,324	3,738	(3,634)	-	31,428	48	2,539	1,310	15,664	-	19,513	48
3. AID ASSOC. FOR LUTHERANS	9,000	651	(360)	2,242	11,533	99	5,253	238	2,433(a)	-	7,924	100
4. ALL AMER. LIFE & CAS. CO.	80	32	5	-	117	18	174	23	206	-	403	51
5. AMER.-AMICABLE LIFE INS. CO.	698	40	(47)	-	691	89	662	319	4,397	-	5,378	51
6. AMER. GEN. LIFE INS. CO.	-	62	(62)	-	-	-	148	14	208	-	370	81
7. AMER. GEN. LIFE INS. CO. OF DEL.	-	97	(97)	-	-	-	2,638	-	-	(440)	2,198	99
8. AMER. GEN. LIFE INS. CO. OF OKLA.	22	18	(40)	-	-	-	64	7	116	-	187	78
9. AMER. HEALTH & LIFE INS. CO.	405	52	(75)	-	382	36	555	94	592	-	1,241	39
10. AMER. HERITAGE LIFE INS. CO.	699	31(a)	- (a)	-	730	100	421	24	228	-	673	85
11. AMER. HOSP. & LIFE INS. CO.	114	- (a)	(1) (a)	-	113	100	49	16	97	65	227	44
12. AMER. LIFE & ACC. INS. CO. OF KY.	502	39	(515)	-	26	3	1,929	101	1,056	-	3,086	92
13. AMER. LIFE INS. CO. OF N.Y.	167	10	32 (a)	-	209	100	28	3	38	-	69	66
14. AMER. MUT. LIFE INS. CO.	900	60	-	121	1,081	90	43	3	4	-	7	8
15. AMER. NATL. INS. CO.	8,252	1,203	(1,867)	-	7,588	43	18,306	974	11,682(a)	-	30,962	100
16. AMER. SLOV. CATH. UNION (KSKJ)	234	13	(5)	-	242	99	-	-	-	-	-	-
17. AMER. UNITED LIFE INS. CO.	1,520	145	-	-	1,665	57	587	33	144	-	764	69
18. ATLAS LIFE INS. CO.	169	18	(1)	-	186	51	43	5	96	-	144	80
19. BALTIMORE LIFE INS. CO.	474	54	-	31	559	54	685	28	222	-	935	100
20. BANKERS LIFE & CAS. CO.	2,694	1,343	(6,192)	2,687	532	4	18,112	837	(1,309)	1,674	19,314	99
21. BANKERS LIFE CO.	6,333	640	(2,086)	-	4,887	39	4,969	578	5,318	-	10,865	56
22. BANKERS LIFE INS. CO. OF NEBR.	1,576	191	(305)	820	2,282	69	5,623	222	1,270(a)	-	7,115	100
23. BANKERS NATL. LIFE INS. CO.	559	67	4	-	630	53	2,450	137	1,232	-	3,819	90
24. BEN RUR LIFE ASSOC.	345	16(a)	(24)	-	337	100	-	-	-	-	-	-
25. BENEFICIAL LIFE INS. CO.	1,001	56	-	63	1,120	100	863	28	26(a)	-	9	100
26. BENEFIT TRUST LIFE INS. CO.	614	43	-	-	657	77	1,169	53	355	-	1,577	89
27. BERKSHIRE LIFE INS. CO.	1,771	271	(284)	503	2,261	55	601	48	948(a)	-	1,597	100
28. BOSTON MUT. LIFE INS. CO.	326	47	(373) (b)	-	-	-	359	40	486	-	885	67
29. BUSINESS MEN'S ASSUR. CO. OF AMER.	957	102	(65)	-	994	50	693	95	223	-	1,011	35
30. CALIF.-WEST'N STATES LIFE INS. CO.	1,731	92	33	-	1,856	100	8,093	453	2,329	37	10,912	72
31. CENTRAL LIFE ASSUR. CO.	3,203	190	(211)	252	3,434	100	2,320	86	453(a)	-	2,859	100
32. COASTAL STATES LIFE INS. CO.	407	29	168(a)	-	584	100	12	77	334	-	423	22
33. COLLEGE LIFE INS. CO. OF AMER.	280	28	(308) (b)	-	-	-	420	99	843	-	1,362	52
34. COLONIAL LIFE INS. CO. OF AMER.	449	73	16	-	538	38	1	4	9	-	14	10
35. COLUMBIAN MUT. LIFE INS. CO.	103	12	(1)	-	114	49	-	1	10	-	11	50
36. COLUMBUS MUT. LIFE INS. CO.	805	75	44	-	924	62	548	66	48	-	662	30
37. COMMONWEALTH LIFE INS. CO.	944	164	(89)	-	1,019	32	756	103	819	-	1,678	55
38. COMPANION LIFE INS. CO.	88	9	-	-	97	51	-	4	16	-	20	17
39. CONN. GEN. LIFE INS. CO.	20,171	2,547	(969)	-	21,749	49	21,076	1,028	10,876(a)	-	32,980	100
40. CONN. MUT. LIFE INS. CO.	22,909	244(a)	-	-	23,153	100	44,146	1,745	-	3,557	49,448	85
41. CONSTITUTION LIFE INS. CO.	268	40	2	-	310	65	863	35	(509)	-	389	37
42. CONTINENTAL AMER. LIFE INS. CO.	953	58	(98)	-	913	79	342	15	100	-	457	92
43. CONTINENTAL ASSUR. CO.	15,040	1,043	(3,498)	5,242	17,827	100	22,113	1,120	14,103(a)	-	37,336	100
44. COUNTRY LIFE INS. CO.	2,253	199	(473)	-	1,979	54	2,288	156	1,311	-	3,755	72
45. CZECHOSLOVAK SOC. OF AMER.	180	11	(8)	-	183	97	-	-	-	-	-	-
46. DURHAM LIFE INS. CO.	395	23	7	-	425	97	-	162	(162)	-	-	-
47. EASTERN LIFE INS. CO. OF N.Y.	197	21	(30)	-	188	45	52	12	122	-	186	46
48. EQUITABLE LIFE ASSUR. SOC.	129,837	6,736	(14,184)	464	122,853	99	70,891	4,156	63,502(a)	-	138,549	100
49. EQUITABLE LIFE INS. CO.	536	54	(30)	-	560	51	87	14	51	-	152	37
50. EQUITABLE LIFE INS. CO. OF IOWA	6,653	385	(661)	-	6,377	86	-	-	-	-	-	-
51. EQUITABLE RESERVE ASSOC.	233	14	5(a)	-	252	100	234	11	113	-	358	100
52. FARM BUR. LIFE INS. CO.	645	103	(239)	206	715	41	67	19	231	39	356	56
53. FARM FAM. LIFE INS. CO.	55	22	54	-	111	27	3	2	12	-	17	26
54. FARMERS & BANKERS LIFE INS. CO.	300	11(a)	(22)	-	289	100	335	27	255	-	617	69
55. FARMERS N' ORLD LIFE INS. CO.	274	32	(197)	-	109	17	1,020	231	600	-	1,851	36

(In Thousands)	TABULATION II															PAGE 2	
	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)					
	BOND	AND	PREFERRED	STOCK	RESERVE	COMPONENT	RATIO	COMMON	STOCK	RESERVE	COMPONENT	COMMON	RATIO				
NAME OF COMPANY	B. & P. S. Reserve 12/31/66	Formula Additions	Capital Gains or Losses	Voluntary Additions & Adjustments	B. & P. S. Reserve 12/31/67	To Maximum	Common Stock Reserve 12/31/66	Formula Additions	Capital Gains or Losses	Voluntary Additions & Adjustments	Common Stock Reserve 12/31/67	To Maximum					
56. FARMERS & TRADERS LIFE INS.CO.	\$ 663	\$ 37	\$ (104)	\$ -	\$ 596	852	\$ -	\$ 4	\$ 31	\$ 9	\$ 44	30%					
57. FEDERAL LIFE & CAS.CO.	104	12	2	-	118	49	-	11	53	-	54	17					
58. FEDERAL LIFE INS.CO.	248	27	-	-	277	57	-	-	-	-	-	-					
59. FIDELITY LIFE ASSOC.	315	35	-	-	350	50	-	-	-	-	-	-					
60. FIDELITY MUT.LIFE INS.CO.	4,228	400	(57)	-	4,571	68	233	107	1,744	-	2,084	59					
61. FRANKLIN LIFE INS.CO.	3,991	508	29	-	4,528	44	35	124	66	-	225	7					
62. GEN.AMER.LIFE INS.CO.	1,538	151	17	-	1,706	58	32	124	1,942	-	2,098	51					
63. GIRARD LIFE INS.CO.OF AMER.	86	5	-	-	91	96	43	21	54	-	118	28					
64. GOLDEN STATE MUT.LIFE INS.CO.	137	10	28	-	175	87	15	6	25	-	46	23					
65. GOVT.EMP.LIFE INS.CO.	278	20	-	-	298	75	-	9	(9)	-	-	-					
66. GREAT NATL. LIFE INS.CO.	168	11	2	-	181	79	50	2	13(a)	-	65	100					
67. GREAT SOUTH'N LIFE INS.CO.	505	68	(7)	-	566	53	3,430	148	735	-	4,313	91					
68. GREEK CATH.UNION OF U.S.A.	404	27	6	-	437	94	-	-	-	-	-	-					
69. GUARANTEE MUT. LIFE CO.	1,050	115	(784)	229	610	31	641	- (a)	(4)	(315)	322	100					
70. GUARDIAN LIFE INS.CO.OF AMER.	5,980	403	(1,132)	-	5,251	72	68	33	761	-	862	77					
71. HARTFORD LIFE INS.CO.	1,201	71	(32)	-	1,240	90	2,250	104	527	-	2,881	83					
72. HOME BENEFICIAL LIFE INS.CO.	1,984	116	3	-	2,103	91	-	23	101	-	124	17					
73. HOME LIFE INS.CO.	4,606	601	(203)	-	5,004	52	255	21	408(a)	-	684	100					
74. HOME LIFE INS.CO. OF AMER.	755	49	(1)	-	803	81	-	5	82	-	87	47					
75. HOME SECURITY LIFE INS.CO.	274	29	(93)	-	210	36	1,041	47	485(a)	-	1,573	100					
76. INDEPENDENCE LIFE & ACC.INS.CO.	44	6	(3)	-	47	42	18	11	68	-	97	35					
77. INDEPENDENT LIFE & ACC.INS.CO.	521	124	(614)	-	31	1	-	100	(100)(b)	-	-	-					
78. INDIANAPOLIS LIFE INS.CO.	799	95	52	-	946	50	416	19	56	-	491	76					
79. INTERSTATE LIFE & ACC.INS.CO.	152	60	(158)	-	54	5	1,539	80	741(a)	-	2,360	100					
80. JEFFERSON NATL.LIFE INS.CO.	392	30	20	-	442	75	646	35	406	-	1,087	94					
81. JEFFERSON STAND.LIFE INS.CO.	6,292	390	112	-	6,794	92	18,980	825	5,372	-	25,177	98					
82. JOHN HANCOCK MUT.LIFE INS.CO.	76,500	5,354	(10,766)	-	71,088	72	99,416	4,789	55,436(a)	-	159,641	100					
83. KANSAS CITY LIFE INS.CO.	2,482	135	(142)	-	2,475	92	17	23	261	14	295	38					
84. KANS. FARM LIFE INS.CO. INC.	132	13	14	-	159	61	41	5	65	-	111	65					
85. KENTUCKY HOME MUT.LIFE INS.CO.	203	11	(16)	22	220	98	439	17	111	11	578	100					
86. LAFAYETTE LIFE INS. CO.	242	27	-	-	269	49	509	23	247	-	779	100					
87. LAMAR LIFE INS.CO.	517	64	(581)(b)	-	-	-	-	101	2,291	-	2,392	71					
88. LIBERTY LIFE INS.CO.	1,428	103	(61)	-	1,470	72	1,994	168	2,655(a)	-	4,817	100					
89. LIBERTY NATL. LIFE INS.CO.	1,453	117	-	234	1,804	77	251	8	-	17	276	99					
90. LIFE & CAS.INS.CO.OF TENN.	3,093	262	(2,813)	-	542	11	4,804	502	10,215(a)	-	15,521	100					
91. LIFE INS.CO. OF GEORGIA	1,540	120	-	-	1,660	69	3,347	182	1,112	-	4,641	77					
92. LIFE INS.CO. OF NO.AMER.	436	64	40	-	540	42	80	23	(70)	-	23	6					
93. LIFE INS.CO. OF VIRGINIA	4,513	449	-	-	4,962	61	8,874	363	-	-	9,237	79					
94. LINCOLN LIBERTY LIFE INS.CO.	158	17	123	-	298	90	1,349	54	385(a)	-	1,788	98					
95. LINCOLN MUT. LIFE INS.CO.	106	9	(6)	-	109	59	77	3	19(a)	-	99	100					
96. LINCOLN NATL. LIFE INS.CO.	18,132	1,522	(5,886)	-	13,768	48	51,694	2,406	20,415(a)	-	74,515	100					
97. LOYAL PROTECTIVE LIFE INS.CO.	554	30	(81)	99	602	100	1,015	42	338	-	1,395	100					
98. LUTHERAN BROTHERHOOD	1,453	155	(193)	-	1,415	68	244	206	2,146	-	2,596	38					
99. LUTHERAN MUT.LIFE INS.CO.	528	89	(22)	-	595	35	-	25	281	-	306	37					
100. MACCABEES MUT.LIFE INS.CO.	89	79	(168)(b)	-	-	-	1,437	63	609(a)	-	2,109	100					
101. MASS.INDEM.& LIFE INS.CO.	15	38	26	-	79	10	-	16	208	-	224	42					
102. MASS.MUT. LIFE INS.CO.	32,071	3,193	(5,961)	23,284	52,587	100	50,595	1,677	3,642(a)	-	55,914	100					
103. METROPOLITAN LIFE INS.CO.	161,754	14,807	617	-	177,178	66	11,718	1,701	8,768	-	22,187	40					
104. MICHIGAN LIFE INS.CO.	131	13	1	-	165	65	157	11	79	-	247	66					
105. MIDLAND NATL.LIFE INS.CO.	564	34	(231)	-	367	57	1,359	49	226	-	1,624	100					
106. MIDWEST'N UNITED LIFE INS.CO.	399	67	(104)	-	362	31	889	49	533	-	1,471	90					
107. MINISTERS LIFE & CAS.UNION	402	54	(32)	6	430	57	1,029	63	1,020(a)	-	2,112	100					
108. MINNESOTA MUT.LIFE INS.CO.	1,041	164	(687)	-	518	17	7,200	390	47	-	7,637	59					
109. MISSOURI UNION TRUST LIFE	67	12	(2)	-	77	36	61	5	91	-	157	100					
110. MODERN WO. N OF AMER.	4,001	- (a)	-	(39)	962	100	5,466	10	- (e)	-	6	100					

(In Thousands) NAME OF COMPANY	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	TABULATION II (20) (21)		PAGE 3 (22)	(23)
	BOND AND		PREFERRED	STOCK	RESERVE COMPONENT	Ratio B. & P.S. Reserve To Maximum	Common Stock Reserve 12/31/66	COMMON STOCK		RESERVE COMPONENT	Common Stock Reserve 12/31/67	Common Stock Ratio To Maximum
	B. & P.S. Reserve 12/31/66	Formula Additions	Capital Gains or Losses	Voluntary Additions & Adjustments	B. & P.S. Reserve 12/31/67			Formula Additions	Capital Gains or Losses	Voluntary Additions & Adjustments		
111. MONUMENTAL LIFE INS.CO.	\$ 1,984	\$ 150	\$ (222)	\$ -	\$ 1,912	65%	\$ 2,710	\$ 137	\$ 1,714(a)	\$ -	\$ 4,561	100%
112. MUT.BENEFIT LIFE INS.CO.	12,130	930	(1,592)	-	11,468	66	7,320	427	4,985	-	12,732	89
113. MUT.LIFE INS. CO.OF N.Y.	41,058	3,268	-	-	44,326	81	24,014	1,465	14,299	-	39,778	82
114. MUT.SAVINGS LIFE INS.CO.	77	18	(7)	-	88	27	134	25	(9)	-	150	20
115. MUT. SERVICE LIFE INS.CO.	258	36	(37)	-	257	48	-	6	63	-	69	37
116. MUT. TRUST LIFE INS.CO.	1,888	190	(140)	-	1,938	58	1,144	40	50	-	1,234	91
117. NATL.FIDELITY LIFE INS.CO.	195	20	20	-	235	60	-	-	-	-	-	-
118. NATL.GUARDIAN LIFE INS.CO.	367	38	119	-	524	69	150	7	(18)	-	139	57
119. NATL. LIFE & ACC.INS.CO.	9,798	893	-	-	10,691	60	10,381	524	5,239	-	16,144	93
120. NATL. LIFE INS.CO.	3,434	412	101	-	3,967	51	1,673	107	1,351	-	3,131	88
121. NATL. OLD LINE INS.CO.	682	53	(44)	-	691	76	-	28	(28)(b)	-	-	-
122. NATL.PUBLIC SERVICE INS.CO.	257	14	11	4	286	100	6	-	5(a)	-	11	100
123. NATL.RESERVE LIFE INS.CO.	454	38	-	-	492	84	256	18	258	-	532	87
124. NATL.STAND.LIFE INS.CO.	63	5	13	-	81	85	79	-	(a)	(1)	78	100
125. NATL.TRAVELERS LIFE CO.	182	25	(39)	-	168	37	1	-	1	-	2	86
126. NATL.WEST'N LIFE INS.CO.	61	38	201	-	300	49	148	31	114	-	293	29
127. NATIONWIDE LIFE INS.CO.	3,206	197	(17)	-	3,386	90	1,500	107	1,940(a)	-	3,547	100
128. NEW ENG.MUT.LIFE INS.CO.	27,681	1,696	(9,476)	-	19,901	62	36,953	1,391	8,010(a)	-	46,354	100
129. NEW YORK LIFE INS.CO.	110,164	6,196	(2,288)	-	114,072	98	72,081	3,407	31,363	-	106,851	94
130. NO.AMER.BENEFIT ASSN.	1,222	32(a)	- (a)	-	1,254	100	248	11	89	8	356	100
131. NO.AMER.CO.FOR LIFE & HEALTH	1,244	76	(32)	-	1,288	87	3,105	231	2,596	-	5,932	77
132. NO.AMER.LIFE & CAS. CO.	428	42	9	-	479	66	400	33	71	-	504	46
133. NO.AMER.LIFE INS.CO.OF CHIC.	338	34	65	-	437	70	962	37	224(a)	-	1,223	100
134. NO.AMER. REASSURANCE CO.	1,207	70	-	-	1,277	97	436	18	107	-	561	92
135. NORTHERN LIFE INS.CO.	1,008	35(a)	- (a)	-	1,043	100	1,316	61	232	-	1,609	78
136. NORTHWEST'N MUT.LIFE INS.CO.	56,090	1,697(a)	(1,046)	-	56,741	100	35,813	1,806	22,593(a)	-	60,212	100
137. NORTHWEST'N NATL.LIFE INS.CO.	1,893	532	(2,942)	8,176	7,659	93	10,656	516	5,283(a)	-	16,455	100
138. OCCIDENTAL LIFE INS.CO.CALIF.	11,658	885	1,004	-	13,547	99	29,848	904	1,548(a)	-	32,300	100
139. OCCIDENTAL LIFE INS.CO.OF N.C.	437	29	65(a)	-	531	100	670	33	(277)	-	426	47
140. OHIO NATL.LIFE INS.CO.	1,346	162	(404)	-	1,104	37	1,031	46	370	-	1,447	94
141. OHIO STATE LIFE INS.CO.	618	63	(40)	-	641	51	448	44	77	-	569	39
142. OLD AMER. INS. CO.	144	18	-	-	162	45	159	13	158	-	330	45
143. OLD LINE LIFE INS.CO.OF AMER.	501	32	5	-	538	84	165	16	(34)	-	147	28
144. PACIFIC MUT.LIFE INS.CO.	2,524	344	(365)	-	2,503	38	2,821	218	1,523	-	4,562	63
145. PACIFIC NATL.LIFE ASSUR.CO.	438	28	(7)	-	459	82	525	38	444	-	1,007	79
146. PAN-AMER. LIFE INS.CO.	1,904	189	(248)	-	1,845	55	832	125	902	-	1,859	44
147. PAUL REVERE LIFE INS.CO.	5,539	561	(2,963)	-	3,137	36	13,873	568	4,503	-	18,944	100
148. PENN MUT.LIFE INS.CO.	19,671	1,553	(4,781)	-	16,443	59	6,085	548	6,963	-	13,596	74
149. PENN.LIFE INS.CO.	138	28	(3)	2	165	35	-	16	147	-	163	31
150. PEOPLES-HOME LIFE INS.CO. IND.	185	15	3	-	203	66	-	-	-	-	-	-
151. PEOPLES LIFE INS.CO. WASH.D.C.	634	80	15	-	729	45	218	17	107	-	342	60
152. PHILA. LIFE INS.CO.	939	93	(141)	-	891	57	1,015	167	1,829	-	3,011	75
153. PHILANTHROPIC MUT.LIFE INS.CO.	113	4(a)	-	-	117	100	13	-	-	-	16	56
154. PHOENIX MUT.LIFE INS.CO.	5,886	582	-	-	6,468	60	5,661	372	3,136	-	9,169	76
155. PYEDMONT SOUTH'N LIFE INS.CO.	103	7	(110)(b)	-	-	-	11,314	466	3,717(a)	-	15,497	100
156. PILOT LIFE INS.CO.	2,984	201	445	-	3,630	100	5,425	127(a)	-	-	5,552	100
157. POLISH WOMEN'S ALL. OF AMER.	212	34	30	-	276	48	-	-	-	-	-	-
158. PRESBYTERIAN MINISTERS' FUND	763	66	(23)	-	806	63	680	61	920	-	1,661	82
159. PROGRESSIVE LIFE INS.CO.	70	9	-	-	79	44	10	1	18	-	29	98
160. PROTECTIVE LIFE INS.CO.	622	46	(213)	-	455	49	1,805	85	954(a)	-	2,844	100
161. PROVIDENT LIFE INS.CO.	334	37	-	-	371	50	2,021	94	992	-	3,107	99
162. PROVIDENT LIFE & ACC.INS.CO.	3,426	244	4	-	3,674	76	1,052	56	91	-	1,199	68
163. PROVIDENT LIFE INS.CO.	7,339	587	(1,242)	-	6,684	58	11,734	407	1,441(a)	-	13,582	100
164. PRUDENTIAL INS.CO.OF AMER.	136,428	14,116	(43,790)	-	26,764	42	229,360	11,061	128,291	-	377,712	100
165. PURITAN LIFE INS.CO.	128	14	(3)	-	139	49	-	-	-	-	-	-

(In Thousands)	TABULATION II											PAGE 4	
	(12)	(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)	(22)	(23)	
	BOND		PREFERRED		STOCK		RESERVE COMPONENT		COMMON STOCK		RESERVE COMPONENT		Common Stock Reserve
NAME OF COMPANY	B. & P.S. Reserve 12/31/66	Formula Additions	Capital Gains or Losses	Voluntary Additions & Adjustments	B. & P.S. Reserve 12/31/67	Ratio B. & P.S. Reserve To Maximum	Common Stock Reserve 12/31/66	Formula Additions	Capital Gains or Losses	Voluntary Additions & Adjustments	Common Stock Reserve 12/31/67	Common Stock Reserve To Maximum	
166. RELIANCE STAND. LIFE	\$ 327	\$ 80	\$ (407) (b)	\$ -	\$ -	-%	\$ 1,990	\$ 153	\$ 1,867	\$ -	\$ 4,010	79%	
167. REPUBLIC NATIONAL LIFE	1,166	114	(140)	-	1,140	74	269	12	11	-	292	74	
168. ROCKFORD LIFE INS. CO.	243	19	(3)	-	259	75	5	2	56	-	63	100	
169. ROYAL NEIGHBORS OF AMER.	1,853	104	59	-	2,016	100	873	27	13	-	913	100	
170. SAFECO LIFE INS. CO.	367	26	(8)	-	385	74	-	-	-	-	-	-	
171. SECURITY BENE. LIFE INS. CO.	1,151	72	(267)	-	956	72	1,366	51	194 (a)	-	1,611	100	
172. SECURITY MUT. LIFE INS. CO. MEMB.	224	21	(51)	-	194	46	104	5	5	-	114	73	
173. SECURITY MUT. LIFE INS. CO. N.Y.	1,296	98	(73)	179	1,500	86	4	1	20 (a)	-	25	100	
174. SENTRY LIFE INS. CO.	58	22	-	-	80	19	68	24	420	-	512	80	
175. SHENANDOAH LIFE INS. CO.	204	37	(27)	-	214	36	602	32	254	-	888	83	
176. SOUTH COAST LIFE INS. CO.	188	13	(2)	-	199	88	51	5	10	-	66	40	
177. SOUTHERN LIFE INS. CO.	73	12	3	-	88	39	-	71	(71)	-	-	-	
178. SOUTHLAND LIFE INS. CO.	361	170	176	-	707	22	1,507	213	(1,720)	-	-	-	
179. SOUTHWEST'N LIFE INS. CO.	4,300	269	109	-	4,678	88	9,959	505	498	-	10,962	67	
180. STANDARD INSURANCE CO.	369	40	(57)	-	352	46	406	33	420	-	859	77	
181. STANDARD LIFE ASSOC.	144	10	(10)	-	144	75	-	-	-	-	-	-	
182. STAND. LIFE INS. CO. IND.	308	37	28	-	373	50	-	8	23	-	31	11	
183. STATE FARM LIFE INS. CO.	4,228	321	(1,570)	1,158	4,137	71	3,029	124	740	249	4,142	100	
184. STATE LIFE INS. CO.	371	36	(2)	-	405	57	-	-	-	-	-	-	
185. STATE MUT. LIFE ASSUR. CO. AMER.	13,778	1,404	689	-	15,871	76	14,829	873	12,956 (a)	-	28,658	100	
186. SUN LIFE INS. CO. OF AMER.	1,703	116	(535)	-	1,184	56	3,068	121	853 (a)	-	4,042	100	
187. SUNSET LIFE INS. CO.	170	22	-	-	192	43	352	15	37	-	404	81	
188. TEACHERS INS. & ANN. ASSOC. AMER.	7,975	913	(195)	1,765	10,458	67	4,255	378	7,128	-	11,761	93	
189. TENNESSEE LIFE INS. CO.	371	45	(11)	-	405	44	-	16	50	-	66	12	
190. TRAVELERS INS. CO.	22,317	2,055	-	-	24,372	68	17,371	806	(617)	-	17,560	66	
191. UNION CENTRAL LIFE INS. CO.	2,530	433	179	-	3,142	37	-	32	384	-	416	39	
192. UNION LABOR LIFE INS. CO.	450	34	18	28	530	79	-	-	-	-	-	-	
193. UNION MUT. LIFE INS. CO.	871	108	(1)	-	978	49	1,141	66	594	-	1,801	81	
194. UNITED BENE. LIFE INS. CO.	3,862	312	(101)	1,048	5,121	82	10,903	358	665 (a)	-	11,926	100	
195. UNITED COMM. TRAV. OF AMER.	93	10	(2)	-	101	49	-	-	-	-	-	-	
196. UNITED FARM BUR. FAN. LIFE INS. CO.	650	54	8	15	727	67	544	22	164 (a)	-	730	100	
197. UNITED INS. CO. OF AMER.	1,050	165	(634)	-	581	18	187	113	942	-	1,242	35	
198. UNITED LIFE & ACC. INS. CO.	151	20	(70)	-	101	25	93	12	211	-	316	80	
199. UNITY MUT. LIFE INS. CO. N.Y.	210	14	5	-	229	80	-	-	-	-	-	-	
200. VICTORY LIFE INS. CO.	392	43	(12)	-	423	52	-	23	(23)	-	-	-	
201. VOLUNTEER STATE LIFE INS. CO.	299	30	(38)	-	291	48	430	29	327	-	786	86	
202. WEST COAST LIFE INS. CO.	304	38	(1)	-	341	45	-	-	-	-	-	-	
203. WESTERN LIFE INS. CO.	751	96	-	186	1,033	59	1,178	85	1,568 (a)	-	2,831	100	
204. WEST'N & SOUTH'N LIFE INS. CO.	3,178	224	-	-	3,402	100	152	11	96	-	259	73	
205. WEST'N STATES LIFE INS. CO.	246	18	33	-	297	87	61	9	157	-	227	73	
206. W.V. PENN. FRAT. ASSOC.	533	31	11	-	575	94	146	- (a)	- (a)	(19)	127	100	
207. WISC. NATL. LIFE INS. CO.	334	32	8	-	374	65	25	6	33	-	64	33	
208. WOODMEN OF THE WORLD LIFE INS. CO.	4,212	262	(545)	496	4,425	100	6,242	200	227 (a)	-	6,669	100	
TOTALS FOR 208 COMPANIES	\$1,197,771	\$96,531	(\$140,137)	\$49,523	\$1,203,688		\$1,149,037	\$60,113	\$552,139	\$4,905	\$1,766,194		

(a) Indicates that company had formula increments or capital gains in addition to amount shown which were not added to reserve due to maximum limitation.

(b) Indicates capital losses were in excess of amount available in Reserve Component to absorb such losses.



## TABULATION III

(In Thousands) NAME OF COMPANY	(24)	(25)	(26)
	Temporary Reserve 12/31/66	Excess Deductions	Reserve Component Temporary Reserve 12/31/67
1. ACACIA MUT. LIFE INS. CO.	\$ 104	\$ (104)	\$ —
14. AMER. MUT. LIFE INS. CO.	154	(1)	153
17. AMER. UNITED LIFE INS. CO.	283	(93)	190
19. BALTIMORE LIFE INS. CO.	105	(37)	68
25. BENEFICIAL LIFE INS. CO.	174	(118)	56
26. BENEFIT TRUST LIFE INS. CO.	917	(395)	522
40. CONN. MUT. LIFE INS. CO.	16,900	(4,231)	12,669
69. GUARANTEE MUT. LIFE CO.	245	(245)	—
70. GUARDIAN LIFE INS. CO. OF AMER.	177	(177)	—
71. HARTFORD LIFE INS. CO.	133	(133)	—
82. JOHN HANCOCK MUT. LIFE INS. CO.	2,802	(2,802)	—
84. KANSAS FARM LIFE INS. CO.	33	(19)	14
86. LAFAYETTE LIFE INS. CO.	41	(21)	20
88. LIBERTY LIFE INS. CO.	613	(613)	—
89. LIBERTY NATL. LIFE INS. CO.	1,083	(76)	992
91. LIFE INS. CO. OF GEORGIA	780	(305)	475
93. LIFE INS. CO. OF VIRGINIA	980	(370)	610
110. MODERN WOODMEN OF AMER.	1,434	(133)	1,251
111. MONUMENTAL LIFE INS. CO.	413	(413)	—
113. MUT. LIFE INS. CO. OF N. Y.	23,071	(5,546)	17,525
116. MUT. TRUST LIFE INS. CO.	87	(87)	—
119. NATL. LIFE & ACC. INS. CO.	4,073	(1,831)	2,242
123. NATL. RESERVE LIFE INS. CO.	25	(13)	12
130. NO. AMER. BENEFIT ASSN.	520	(117)	403
134. NO. AMER. REASSURANCE CO.	516	(257)	259
151. PEOPLES LIFE INS. CO.	46	(46)	—
152. PHILADELPHIA LIFE INS. CO.	12	(12)	—
153. PHILANTHROPIC MUT. LIFE INS.	22	(10)	12
154. PHOENIX MUT. LIFE INS. CO.	2,927	(1,490)	1,437
156. PILOT LIFE INS. CO.	66	(66)	—
162. PROVIDENT LIFE & ACC. INS. CO.	400	(301)	99
169. ROYAL NEIGHBORS OF AMERICA	527	(147)	380
190. TRAVELERS INS. CO.	1,378	(1,378)	—
192. UNION LABOR LIFE INS. CO.	100	—	100
196. UNITED FARM BUR. FAM. LIFE	337	—	337
203. WESTERN LIFE INS. CO.	432	(47)	385
204. WESTERN & SOUTH'N LIFE INS. CO.	562	(339)	223
206. WILLIAM PENN FRAT. ASSN.	114	(35)	79
TOTALS FOR 38 COMPANIES	<u>\$62,571</u>	<u>\$ (22,058)</u>	<u>\$40,513</u>

SUPERINTENDENT STEWART: Mr. President, I move the receipt of this report and, since I am aware of no controversy, its adoption.

PRESIDENT BENTLEY: You have heard the report and the motion for its adoption. Is there a second?

COMMISSIONER MASTOS: Second.

PRESIDENT BENTLEY: The motion has been seconded by Commissioner Mastos. Is there any objection to the adoption of this report? The Chair hears none and the report is adopted.

**PRESIDENT BENTLEY:** The Committee on Advertising of Insurance, Committee H, is headed by Commissioner Frank Montgomery of West Virginia, who is recognized for his report.

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ADVERTISING OF INSURANCE (H) COMMITTEE

AGENDA - MTG. NO. 32

TUESDAY A.M.

JUNE 18, 1968

9:00-10:15

GALLERIA 2

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Reference

1967 Proc. VOL. II pp. 581-582

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1. Any matter submitted for consideration.
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ADVERTISING OF INSURANCE (H) COMMITTEE Report  
(Mtg. 32)

Pursuant to a letter submitted in advance, South Carolina raised for discussion the problem of cancellation or refusal to renew automobile liability insurance and its possible relationship to advertising which may induce applicants for insurance to change their positions as the result of inducements, such as price, only to find themselves cancelled or refused renewal after which they are reasonably certain to find themselves in the Assigned Risk Plan.

After considerable discussion it was moved, seconded and unanimously resolved that this subject be placed on the agenda of the December meeting for the purpose of considering the possible appointment of a subcommittee for in-depth consideration of the problem and possible solutions.

Hon. Frank R. Montgomery, Chm., W. Va.; Hon. Robert D. Preston, V.Chm., Ky.; Hon. Jerry P. Shea, Ariz.; Hon. Allan W. Horne, Ark.; Hon. Broward Williams, Fla.; Hon. Edwin H. Honda, Hawaii; Hon. John R. Blaine, Ida.; Hon. Frank Sullivan, Kan.; Hon. Robert D. Scharz, Mo.; Hon. Elmer V. Omholt, Mont.; Hon. Louis T. Mastos, Nev.; Hon. Edwin S. Lanier, N. C.; Hon. K. O. Nygaard, N. D.; Hon. David O. Maxwell, Pa.; Hon. Ralph A. Petrarca, R. I.; Hon. Charles W. Gambrell, S. C. by Howard B. Clark; Hon. C. N. Ottosen, Utah; Hon. William G. Walton, Wyo.

**COMMISSIONER MONTGOMERY:** Mr. President, I move the report be received and adopted.

**COMMISSIONER MASTOS:** Second the motion.

PRESIDENT BENTLEY: You have heard the motion for the adoption of the report and Commissioner Mastos again has seconded it. Is there any objection to the adoption of this report of the Committee on Advertising of Insurance? The Chair hears none and the report is adopted.

**PRESIDENT BENTLEY:** The Chair appointed Commissioner Haase of Wisconsin as Chairman of a committee to draft resolutions for this convention and he is now recognized for a report of his Committee on Resolutions.

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### RESOLUTIONS COMMITTEE Report

**BE IT RESOLVED**, that the National Association of Insurance Commissioners convened in the City of Portland, Oregon, for its 1968 Annual Meeting and expresses sincere appreciation to the Honorable Tom McCall, Governor, for his message of welcome, and the National Association of Insurance Commissioners expresses its gratitude and appreciation to the Honorable James R. Faulstich, Commissioner of Insurance, and his staff and the people of this City of Roses and Snow-capped Mountains for making this meeting a most memorable occasion.

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**WHEREAS**, it takes dedicative effort by many people for many months to arrange a meeting of more than 1,500 persons, and close attention must be given to hundreds of details in order to insure a productive and enjoyable meeting,

**THEREFORE, BE IT RESOLVED**, that the National Association of Insurance Commissioners expresses its sincere appreciation to all of the members of the Industry Committees who assisted in the Convention and in particular to W. A. "Pete" Brooks, General Chairman, and to Committee Chairmen and Committeemen: J. Chapman, William F. Gaarenstroom, and Waldo Sears, Finance; V. Dean Musser and James Osborne, Hospitality; Donald Byhre and Mollie Blumenthal, Facilities; Philip D. Lang, Marshall Dunkin, Dick Clement and John Miller, Meetings & Reports; C. Robert Wells, Registration; Walter J. Korlann and Robert Mohlere, Welcoming Comm.; James H. Maloney, Transportation; Rudy B. Miner, Public Relations; and Mrs. Fretchen Faulstich, Hostess Comm.

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**WHEREAS**, The Weekly Underwriter has published since 1916, the rulings promulgated by the several insurance departments; and has furnished each department printed copies of such rulings, together with a subject index, without charge to the departments; and

**WHEREAS**, these rulings have proven to be of very great value to the several departments,

**NOW, THEREFORE, BE IT RESOLVED**, that this Association

recommends the continuation of the practice of sending all rulings as soon as promulgated to the Weekly Underwriter as the central clearing house for this information, to the end that this complimentary service to the insurance departments may be as prompt, complete and accurate as possible.

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WHEREAS, the National Association of Insurance Commissioners is constantly aware of the efficient and dedicated service rendered by its Executive Secretary, Mr. Hugh L. Tollack, and the members of his staff not only at this Convention but throughout the year, and,

WHEREAS, Mr. Hugh L. Tollack has been a loyal employee of the National Association of Insurance Commissioners for the past eighteen years,

THEREFORE, BE IT RESOLVED, that the National Association of Insurance Commissioners expresses its sincere gratitude and appreciation to Mr. Hugh L. Tollack and to his staff for their loyal and competent service.

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WHEREAS, the recording and reproduction of the many thousands of pages of Committee Reports is an enormous task of coordination of the work of many people recruited from various offices and,

WHEREAS, it is necessary and desirable that there be continuity in the administrative assistance and supervision of this work from Meeting to Meeting and,

WHEREAS, Mr. Dale Dodge, Vice President of Great Central Insurance Company, Peoria, Illinois, has given of his services in this capacity at each of the meetings of the National Association of Insurance Commissioners since 1962.

THEREFORE, BE IT RESOLVED, that the National Association of Insurance Commissioners expresses its sincere appreciation to the personable Mr. Dale Dodge for his valuable assistance in the administrative details of the printing and dissemination of Committee Reports.

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WHEREAS, substantial and substantive progress has been made by this Association in many areas during the past six months as a result of outstanding work and leadership by Committee Chairmen and also as a result of the dedicated efforts by Industry Advisory Committees.

THEREFORE, BE IT RESOLVED, that the members of the National

Association of Insurance Commissioners publicly acknowledges and commends such efforts as being consistent with the highest ideals and purposes of this Association.

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Hon. Robert D. Haase, Chm., Wis.; Hon. W. W. Fritz, Alaska; Hon. Jerry P. Shea, Ariz.; Hon. Frank M. Hogerty, Jr., Maine; Hon. Elmer V. Omholt, Mont.; Hon. William G. Walton, Wyo.

COMMISSIONER HAASE: Mr. President, I move the adoption of these resolutions.

PRESIDENT BENTLEY: Well done, Mr. Chairman. Is there a second to this motion?

COMMISSIONER MASTOS: Second.

PRESIDENT BENTLEY: Is there objection to the adoption of these resolutions? The Chair hears none and the report is adopted.

**PRESIDENT BENTLEY:** There are a few announcements the Chair would like to make here. During the past six months considerable activity has developed across the national scene on the internal business of automobile insurance, and we think that it is very appropriate, in the light of the several investigations under way, by the State Department, by the Department of Transportation, by Senator Hart's committee, the several industry inquiries that are under way, we think it is desirable that a committee of this Association be delegated with authority to re-examine and appraise both the past and the current activities of the developments in connection with the questions being raised about automobile insurance, and your Chairman hereby delegates Commissioner Lorne Worthington of Iowa as the chairman of this committee, to be assisted by Commissioner Stewart of New York, Robert Haase of Wisconsin, Commissioner Faulstich of Oregon, Charles Howell of New Jersey, James Bentley of Georgia and George Cowden of Texas. This committee is delegated the authority of re-examining and appraising all of the developments and coordinating the activities of this Association.

Some Commissioners have already been invited to appear in Washington and testify and others undoubtedly will have an opportunity to go and be invited to testify. All of us are now to be aware of the fact that this committee is now given the authority to move in coordinating all of these activities and doing great research, which it now has the staff personnel to assist, and legal counsel in Washington to assist in these activities. And certainly we should have an opportunity to pull together the information in the months ahead to qualify and justify this Association to go in at a much later date in the hearings and make a report, which undoubtedly will be a responsible report.

Now, there is another subject which has not been mentioned in great detail at this convention and this is that this Association has enjoyed the great cooperation of the College of Insurance in New York, the great success we have had with our training program, seminars for new Commissioners and seminars for examiners. The Georgia Department has participated in both instances and has benefited graciously and generously as a result of these programs that we have begun this year and that we hope will continue indefinitely into the future. There are now I believe six vacancies in the examiners' program to begin later this year, — the Commissioners' program, to begin later this year. We urge all of you to attend and urge your examiners to attend. It is an economical sort of a program and it is a highly beneficial program for both Commissioners and examiners, and we urge you to participate. And if you feel you are sufficiently knowledgeable and wise and skilled, send your second and third echelon personnel, who likewise will benefit from this program. It is a tremendously impressive one. We have begun this process of examination and education for our people and we can't let it begin lagging in enthusiasm.



The program for examiners, I think Jim Faulstich is a good example of one who has participated and benefited. Commissioner Fritz also has participated and we urge you to participate.

There is one other item that your Chairman would like to refer to briefly here. You have heard three Commissioners make reports this morning who won't be with us at our December session, Commissioners who have made profound contributions to this Association in past years, and in some instances over a period of years. Lee Kueckelhan has led us as President of this Association; he has led us with exhaustive and vigorous pursuit of his responsibilities as Examinations Committee Chairman and other responsibilities here. He chose not to run for reelection and he won't be with us next time.

And Don Knowlton, who likewise has contributed magnificently to this Association and likewise served as President of the Association, won't be with us at our next meeting. He has chosen to retire in a matter of days. And likewise we are profoundly indebted to this man for his great courage and great determination, and has a broad grasp of the needs of this Association. Likewise, we will miss you, Don.

And one who has not served as President of this Association but who should have, because of his initiative and ability and great wisdom and his tremendous character to move in and to stand when others might not have stood. When he didn't know what the outcome might be, yet he stood for what he thought was responsible. Dick Roddis of California has chosen to enter the field of academic pursuits in the Law School of the University of Washington before our next session.

These three great leaders in our ranks here will leave a real gap in our ranks, because there is no substitute for this kind of leadership, and I think it is appropriate that we all pause a moment to salute these gentlemen, they having made their last committee reports and attended their last meeting of NAIC, salute them and thank them for their contributions. (Applause as all stand)

Now, gentlemen, we have apparently concluded all of our Second Plenary Session business in open session and I don't see any necessity of an executive session. We now have a third plenary session scheduled here, and I think at this time we will pass the torch of this Association. We would prefer to do that in private and we will therefore express our gratitude to you representatives of the industry for your good contributions and participation here. We thank you for your attendance here, for your great hospitality here and for your great contributions here and we will now excuse you and adjourn this Second Plenary Session and immediately convene the Third Session.

1968 ANNUAL MEETING  
JUNE 16 - 21, 1968  
PORTLAND HILTON HOTEL  
PORTLAND, OREGON

ORDER OF BUSINESS

THIRD PLENARY SESSION - MTG. 50 FRIDAY - 9:30 A.M.  
JUNE 21, 1968  
BALLROOM A

PRESIDING  
HON. JAMES L. BENTLEY, PRESIDENT - GEORGIA

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1. CALL TO ORDER 1968 ANNUAL MEETING OF THE  
PLENARY EXECUTIVE SESSION - 3 NATIONAL ASSOCIATION OF  
INSURANCE COMMISSIONERS

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2. SERGEANT-AT-ARMS

NOTE: You may wish to remind the Sergeant-at-Arms that this Meeting is in  
EXECUTIVE SESSION, and attendance is confined strictly to NAIC  
MEMBERS and their STAFF MEMBERS.

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3. AUTHORIZED REPRESENTATIVES OF MEMBERS

NOTE: You may wish to announce again that LETTERS OF AUTHORITY, in  
accordance with ARTICLE 4 of the NAIC CONSTITUTION, are necessary  
before REPRESENTATIVES are permitted to vote.

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4. ROLL CALL HON. RALPH F. APODACA  
(Only if quorum is DOUBTED) SUPERINTENDENT OF INSURANCE  
STATE OF NEW MEXICO  
SECRETARY-TREASURER

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5. REPORTS OF COMMITTEES (See pages 368-369)

NOTE: Following the procedure of recent Meetings, ONLY those COMMITTEE  
REPORTS which were RECEIVED (and NOT ADOPTED) during PLEN-  
ARY SESSION - 2 will be submitted to this Meeting for FINAL ACTION.

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6. ELECTIONS - APPOINT ELECTION TELLERS (if desired).

HON. ....

HON. ....

HON. ....

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7. ELECTION OF PRESIDENT - Open for nominations.

PRESIDENT ELECT - HON. ....

Comments (if any)

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8. ELECTION OF VICE-PRESIDENT - Open for nominations.

VICE PRESIDENT ELECT - HON. ....

Comments (if any)

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9. ELECTION OF SECRETARY-TREASURER - Open for nominations.

SECRETARY-TREASURER ELECT - HON. ....

Comments (if any)

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## 10. ELECTION - EXECUTIVE COMMITTEE CHAIRMAN - Open for nominations.

(A) CHAIRMAN ELECT - HON.-----

Comments (if any)

(B) THREE (3) MEMBERS-AT-LARGE - Open for nominations.

1.-----

2.-----

3.-----

## 11. ZONE REPORTS

1. HON. C. EUGENE FARNAM - MASS.

ZONE CHAIRMAN

HON.-----

ZONE EXECUTIVE COMMITTEE REP.

HON.-----

2. HON. FRANK R. MONTGOMERY - W. VA.

ZONE CHAIRMAN

HON.-----

ZONE EXECUTIVE COMMITTEE REP.

HON.-----

3. HON. DAVID M. PACK - TENN.

ZONE CHAIRMAN

HON.-----

ZONE EXECUTIVE COMMITTEE REP.

HON.-----

4. HON. JOHN F. BOLTON, JR. - ILL.

ZONE CHAIRMAN

HON.-----

ZONE EXECUTIVE COMMITTEE REP.

HON.-----

5. HON. WILLIAM G. WALTON - WYO.

ZONE CHAIRMAN

HON.-----

ZONE EXECUTIVE COMMITTEE REP.

HON.-----

6. HON. LEE. I. KUECKELHAN - WASH.

ZONE CHAIRMAN

HON.-----

ZONE EXECUTIVE COMMITTEE REP.

HON.-----

## 12. EXAMINATIONS COMMITTEE - ELECTION

CHAIRMAN

HON.-----

VICE-CHAIRMAN

HON.-----

NOTE: If the Members of the EXAMINATIONS COMMITTEE have not already elected their respective CHAIRMAN and VICE-CHAIRMAN, it is suggested they do so in accordance with the NAIC CONSTITUTION ARTICLE 6, and report at this SESSION for COMMITTEE LIST information.

13. ANNOUNCEMENTS (if any).

(A) HON. RICHARD S. L. RODDIS - CALIFORNIA

RE: 1968 REGULAR MEETING  
DECEMBER 2 - 6, 1968  
CENTURY PLAZA HOTEL, HDQTRS.  
LOS ANGELES, CALIFORNIA

(B) ANY OTHER ANNOUNCEMENTS

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14. NAIC MEMBERS ONLY - EXECUTIVE SESSION (if desired).

NOTE: No transcript will be made. Therefore, the discussion should be confined to those subjects on which NO RECORD is desired for future reference.

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15. ADJOURNMENT OF THE 1968 ANNUAL MEETING.

TIME.....A.M. - P.M.      DATE....., 1968

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## — PLENARY SESSION - 3 —

PRESIDENT BENTLEY: The third Plenary Session of this meeting will come to order. Sergeants-at-Arms, will you advise that this is an executive session and that no one is permitted here except Commissioners, their staffs and members of their distinguished families. Will the Sergeants-at-Arms please see to it that no other personnel are in this meeting.

Are there other representatives of Commissioners here whose letters of authority have not been submitted? We have 15 letters of authority from 15 Commissioners of Insurance Departments authorizing their substitutes to participate here.

Does the Chair hear a motion that we dispense with the calling of the roll here this morning?

COMMISSIONER HAASE: I so move.

COMMISSIONER MASTOS: Second the motion.

PRESIDENT BENTLEY: The motion has been made and seconded that we dispense with the roll call. A quorum is declared present.

We have completed the adoption of all committee reports and there appears to be no other business unless some other Commissioner or Department has some business for this executive session. Is there any other item of business of concern to anyone? There appears to be no other business.

We will need tellers to count the votes in this session and the Chair appoints Commissioner "Sonny" Omholt as chairman of the group to participate in counting the votes, Mr. John Blaine of Idaho to assist him and Commissioner Honda of Hawaii to assist him. Are those three Commissioners present? It will be your responsibility to collect and count the votes, and I think you would better prepare some ballots.

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PRESIDENT BENTLEY: First, we now proceed to choose the next President of this Association and the floor is open for nominations for the office of President of the National Association of Insurance Commissioners. The Chair recognizes Mr. Jim Hunt.

COMMISSIONER HUNT: Mr. President, it gives me a great deal of pleasure and I count it a singular honor to place in nomination for the Presidency of the National Association of Insurance Commissioners a good friend of us all, my benefactor at the bridge table

(Laughter), the Good Humor Man from New Jersey, the Commissioner of Banking and Insurance of that great state, the Honorable Charles Howell.

In these difficult insurance times, the commanding De Gaulle-like presence of Commissioner Howell as head of this great organization is indeed fortunate for us all.

Charles Howell made no plans at the bridge table last night, unfortunately for him, fortunately for me, but today, if elected, this noble man will complete the grand slam of the regulatory business, for Mr. Howell has already served a term as President of the National Association of State Supervisors of Banks, an association of which I am also a member, and will become the first and probably the last man to accomplish this feat. Need anything else he said? While I was taught when young never to trust a man with a mustache, in this special case I have no compunction at all about nominating for President the swinger from New Jersey, the great Charles Howell. Thank you. (Applause)

PRESIDENT BENTLEY: Is there a second to this nomination?

COMMISSIONER KUECKELHAN: Mr. Chairman, I deem it a great honor to second the nomination of Charlie Howell and I am delighted to see him in this position.

PRESIDENT BENTLEY: Thank you, Mr. Kueckelhan. Are there other seconds to this nomination? Are there other nominations?

COMMISSIONER DYKHOUSE: I move the nominations be closed.

COMMISSIONER HAASE: I second the motion.

PRESIDENT BENTLEY: Is there objection? The Chair hears none. The nominations are closed. Commissioner Howell, we declare you President of the National Association of Insurance Commissioners. (Prolonged applause as all stand)

COMMISSIONER HOWELL: Mr. President and all of my colleagues and friends here, I am sure you all understand how much I appreciate the honor and the responsibilities that you have voted me today. I am following a man who is going to be very, very difficult to keep up the pace of accomplishments of my great and good friend, Jim Bentley, and a number of his predecessors in this office. I would like to say I think it is in order to pay great tribute to Jim and to the predecessors in this job who set up the machinery for the reorganization of this great Association. Jim Bentley has been outstanding in that. It wouldn't be

fair to mention many of the others who have assisted so effectively in bringing this about. Nelson Parker, of course, was a great tower of strength in helping Jim, as were others, in bringing about these accomplishments. But I do feel that despite the fact that this Association has had a great record of effective accomplishments in the field of insurance regulation over many, many years, the product of the reorganization efforts accomplished largely under Jim Bentley's leadership has put us in a position now where we are going to be able to move even more effectively. We are going to have available to us talents in our Central Administrative Office that I feel are going to be of great benefit not only to the Association but to the individual Commissioners in their respective jurisdictions.

This new Central Office will not attempt to set policy but it will provide us with the knowledge, the basic research and the information so necessary for us to make effective answers to the very many problems that we are faced with today, and I look forward to doing my job next year with much greater confidence that I can deal with it, knowing that I will have the back-up that is going to be supplied by men like Bob Dineen and John Hanson and all of you who I have worked with here for many years. I think we are really going to move; I think we are going to create a great record, but it is going to require the assistance, the support and the cooperation of every one of my colleagues in this Association.

I deeply appreciate your bestowing on me this honor and the responsibility that goes with it. I might say before I sit down that I will be glad to hear from all of the Commissioners as to any special desires they have for committee assignments. I will do my best to reconcile them with the practicalities and the situations that exist and where I possibly can cooperate, I want very much to do it. I would appreciate very much hearing from any of you who have any special desires for continuation on or appointment to the various important committees of this organization.

I again want to thank you. I look forward to a year where you will work with me and, if that happens, I am sure we can go forward and establish a great record with the assistance of Ned Price and whoever is to succeed him as Chairman of the Executive Committee and the members of that Executive Committee. Thank you. (Applause)

PRESIDENT BENTLEY: Thank you, Charlie.

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PRESIDENT BENTLEY: This Association needs a Vice President. I declare nominations open for the Vice Presidency of this Association.

MR. FAIRCLOTH: President Bentley, members of the National Association of Insurance Commissioners, ladies and gentlemen:

One year ago, this Association in its considered judgment and far-sightedness saw fit to elect as Chairman of its Executive Committee a man who has made his influence felt in a very forceful way. During the fiscal year now closing, all of us can testify to the fact that this individual in his expanded capacity on every occasion has served, and served well, this Association. It is therefore only fitting and proper that he be elevated to the Vice Presidency of the National Association of Insurance Commissioners. So, on behalf of Commissioner Williams of Florida, whom I represent at this time, and on behalf of those in the Department who do the work, it is my pleasure to place in nomination the name of a great Texan, The Hon. Ned Price, for Vice President of this great Association. (Applause)

PRESIDENT BENTLEY: You have heard the nomination. Is there a second? I recognize Dick Roddis.

COMMISSIONER RODDIS: Last year at this convention it was my pleasure and privilege to nominate Ned Price as Chairman of the Executive Committee of this Association. Without recounting his background as a judge, a legislator, and since 1960 an active member of the State Board of Insurance of Texas, I reflected the conviction that he would serve this Association faithfully and well. Apparently this belief was commonly shared for Ned was elected without dissent.

The wisdom of that choice has been vindicated by the experience of the past year, during which Ned has served as Chairman of the Executive Committee. He has been diligent and dedicated. I will not attempt to recount his accomplishments. Rather, I would mention but a few salient points he has demonstrated.

First, I am sure that Jim Bentley would attest to the support and cooperation that he has received as President from Ned Price.

Second, he has conducted the Executive Committee meetings with dignity, parliamentary excellence and complete impartiality. This latter quality is worth emphasizing. Ned has always exercised the greatest care to see that an ample opportunity is afforded for expression of all viewpoints and to see that all are given full and fair consideration.

Ned Price has served us well. You may rely upon him to do so again and again in the future. California is proud to second the nomination for Vice President of this Association of the Hon. Ned Price, member of the State Board of Insurance of the Great State of Texas. Thank you. (Applause)



PRESIDENT BENTLEY: The nomination has been seconded. Are there other seconds for the Vice Presidency of this Association?

Oklahoma takes pride in seconding the nomination of Ned Price for Vice President of the Association.

COMMISSIONER SULLIVAN: I wish to second the Nomination of Ned Price.

MR. GRAIG: South Carolina is happy to second the nomination of Judge Price.

PRESIDENT BENTLEY: Thank you, Glen. Are there other nominations?

COMMISSIONER KUECKELHAN: I move that the nominations be closed and Ned Price be elected by acclamation.

COMMISSIONER SULLIVAN: I second the motion.

PRESIDENT BENTLEY: The motion has been made and seconded that the nominations be closed and Judge Price be designated Vice President of this Association unanimously. Is there objection to the adoption of this motion? The Chair hears none and congratulations, Ned. (Applause)

COMMISSIONER PRICE: Thank you very much, Jim. I wish my wife's mother could have been here to hear all those nice things about me. (Laughter)

And to all of you generous people who rose to second my nomination and to Ed. Faircloth, who placed my name in nomination, I'll meet you and give you cigars and dinners later. (Laughter)

I am indeed honored, gentlemen, to have been selected as your Vice President. I have enjoyed very much my year of service as Chairman of the Executive Committee. I hold for each and every one of you an affection. I feel that the greatest opportunity for service that will ever come my way and that has come my way up to now has been in this work with the NAIC.

I have been very much impressed with the great service of Jim Bentley and his immediate predecessors, in the work that they have done. I share President Howell's views in this regard. I look forward to working with Charlie Howell. Charlie and I have been associated together now for a number of years. We haven't always agreed but we have cooperated and worked in our respective ways, we hope for the best interests of this NAIC.

I am highly honored and I am at your service. I consider myself your servant in this year ahead and I will be available at any time to do what I can to help you and to help this great organization to which we belong. Thank you so much. (Applause)

PRESIDENT BENTLEY: Thank you, Judge Price.

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PRESIDENT BENTLEY: The next vacancy to be filled in this Association is the office of Secretary-Treasurer. The Chair declares the floor open for nominations for the office of Secretary-Treasurer of the National Association of Insurance Commissioners.

COMMISSIONER MASTOS: I take great pride today in arising to nominate this gentleman whom I will propose. You have all known him for many, many years of service. In fact, I think he would be at this time the dean of the Commissioners within our organization. He is not only the court jester but a very dignified gentleman in his approach to the problems facing, and that he has faced, in the operations of the office of Secretary-Treasurer of this organization. I therefore take great pride and pleasure today in nominating our senior member, the Hon. Ralph Apodaca from the State of New Mexico, for the office of Secretary-Treasurer. (Applause)

PRESIDENT BENTLEY: Is there a second to this nomination?

COMMISSIONER BARNES: There is usually a rose between two thorns and as one of those two thorns, I second the nomination of the rose. (Laughter)

PRESIDENT BENTLEY: Are there other seconds to this nomination? Are there other nominations?

COMMISSIONER HAASE: I move the nominations be closed.

MR. FAIRCLOTH: I second the motion.

PRESIDENT BENTLEY: The Chair hears a motion that the nominations be closed and Mr. Apodaca be elected by acclamation. The motion has been made and seconded. Is there objection to the adoption of this motion? The Chair hears none and, Ralph, you are again elected Secretary-Treasurer of this Association. Congratulations. (Applause as all stand)

COMMISSIONER APODACA: I am very grateful for the honor that has come to the great State of New Mexico and our people, because I feel that I have to share this great honor. Over the years you have

bestowed this kind of honors and I think I have been very lucky to have been worthy of coming back and still be able to share with my fellow Commissioners some of our trials and tribulations.

I also am delighted to have had the honor of working with the future Governor of Georgia. (Laughter) I have always felt that if I lost my job, I could perhaps be a water boy in Georgia. (Laughter)

I also would like to express my sincere appreciation to Hugh Tollack, who has been my right hand, you might say, in bridging the gap of the work of the Association, for his efforts, his sincerity and devotion. When you need him, he always has been available. I am very grateful to have had the opportunity of working with him.

And I want to thank all of the Commissioners also for the wonderful response that they made when Jim Bentley and the Executive Committee decided to reorganize the NAIC with more money. When the call was issued from my office, the response was magnificent, so overwhelming that we oversubscribed the amount that was called for. This is something that I am very grateful to you for, because it makes my job that much easier. I hope that I can be with you for many years to come, and thank you very much. (Applause)

PRESIDENT BENTLEY: Thank you very much, Ralph.

COMMISSIONER BARNES: Mr. President, through inadvertence we have created an error. The Constitution and Bylaws say that no officer may serve more than two years in succession. You can succeed yourself twice but not more. Mr. Apodaca, the honorable, almost honorable, has served for the last two consecutive years as the duly elected Secretary-Treasurer and he therefore cannot succeed himself. May I suggest that we place him in position as the Acting Secretary-Treasurer and then he doesn't succeed himself? We just don't have any, he is just acting as such. I so move.

PRESIDENT BENTLEY: You have heard the motion. Is there a second?

COMMISSIONER MASTOS: Second.

PRESIDENT BENTLEY: The motion is made and seconded that we declare Mr. Apodaca is serving here as Acting Secretary-Treasurer of this Association. This is not personal, gentlemen. We have been doing this every third year for some while. Is there objection to the adoption of this motion? The Chair hears none and therefore, Ralph, you are Acting Secretary-Treasurer of this Association.

COMMISSIONER APODACA: Do I have to make another speech? (Laughter)

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PRESIDENT BENTLEY: Now the Chair declares the floor open for the filling of the next office to be filled in this Association, the election of the Chairman of the Executive Committee. I recognize Mr. Don Knowlton.

COMMISSIONER KNOWLTON: Mr. President and members of the Association, it is a great privilege and honor for me to appear before you for the purpose of nominating Richard E. Stewart, the Superintendent of Insurance of New York, for the office of Chairman of the Executive Committee.

I could recite at some length his qualifications for that office. I could point out his educational qualifications. I could point out that he is a graduate of the University of West Virginia, a Rhodes Scholar at Oxford. He is a graduate of Harvard Law School cum laude, and took the Roscoe Pound prize. I could point out that after military service he engaged successfully in the practice of law, was later appointed Assistant Counsel to the Governor of the State of New York and then became First Assistant Counsel to the Governor.

I think it is particularly interesting that he also served with the Joint Legislative Committee on Interstate Cooperation, because that is the kind of thing that we encourage in this organization.

These are some of his qualifications, but there is no need of exploring them any further because you all know him and you know that he has all those qualifications.

I'd like just for a moment to dwell on two or three things that seem to have been mentioned in the corridors of this Association having to do with nomination to this office. One is the fact that some people have suggested that Dick has not been long enough in office. He has been Superintendent of the State of New York for a year and one-half and certainly it seems to me that with the educational qualifications that he undoubtedly has, and his experience in this Association during that time, it is a little difficult to say that he hasn't been long enough in office.

I have also heard it suggested that perhaps this is too soon for Zone I to again seek office, and in that respect I remind you that since 1955, when I was honored to be President of this Association, we have only had one President elected from Zone I and that is the man that you just elected. That is a period of, well, by the time the present incumbent becomes President, it will have been a period of 15 years.

I have also heard the remark that New York runs the country; that a concentration of power might be expected if you elected a man from that state to office.

This kind of talk just amazes me, because I have lived through I don't know how many Superintendents from the State of New York in the last 25 years and I can assure you that this thing hasn't happened and that it won't happen. New York not only doesn't attempt to dominate this Association but New York has contributed in money and in research and in the effort of the Superintendent and the members of its Department a great deal to this Association, and therefore it gives me great pleasure to nominate a fair, honest, able and energetic man as Chairman of the Executive Committee and recommend to you the Hon. Richard E. Stewart. (Applause)

**PRESIDENT BENTLEY:** Thank you, Don Knowlton. Are there seconds now to this nomination? Commissioner Dirks.

**COMMISSIONER DIRKS:** Fellow members of this Association, I think you will all agree with me that at the present time the regulators of the insurance industry are probably faced with the greatest number of major problems that we have ever faced. Just to name some of them, riots and civil commotion, holding companies, flood control, automobile insurance. These are real serious problems. The answers to them are not going to come quickly and the solutions will not be easy. It is important, I think, that we have the type of people who have the ability and the experience necessary to cope with these types of problems. The problems don't stop at this point.

At the present time I think you would all agree with me that the cloud of federal regulation probably hangs more darkly over state regulation than it ever has. There are federal officials who feel that they have a monopoly on the answers to these problems and that they can best solve them. Of course, I do not concur in that opinion and I am sure that you do not either. But it is a matter that we have to reckon with.

Again, this is going to call for a lot of tact and diplomacy and experience to satisfy the federal government that this organization does have the ability within its ranks to solve these problems.

Sometimes this Association is criticized for failing to act at all or for acting improperly when they do act. I think that by the election of Dick Stewart to the position of Chairman of the Executive Committee, we can do very much to handle all of these issues that I have mentioned. He has contributed substantially to this organization during his brief period in the organization. His intellect, his energy, his enthusiasm, have all stood out. I think you have all recognized it in the brief time that he has been with us.

He has had experience already with the people in Washington, D. C.; he has been down there and testified on a number of occasions before them; I think he has contact with many of the departments and he has a department behind him that can help him very much in doing the work that we expect of him. By nominating him and electing him, I am certain that we can't be criticized for not doing the right thing at the right time, and I feel privileged and I feel it is an honor for me to second the nomination of Dick Stewart and I hope that you will support him. Thank you. (Applause)

PRESIDENT BENTLEY: You have heard the second. Are there other seconds?

COMMISSIONER RODDIS: Mr. President, it is with deeply mixed personal emotions that I shortly leave office as Insurance Commissioner of California and as a member of this Association, a feeling, I might add, which has been compounded by Jim Bentley's kind remarks and by the coincidence that I leave in the same year that two great leaders like Don Knowlton and Lee Kueckelhan also end their long service. This — and I am sure it is a source of comfort to some — is undoubtedly the last occasion on which I will speak to you as a fellow member. I am proud that this last act is taken on behalf of the State of California in seconding the nomination of Richard Stewart for the office of Chairman of the Nominating Committee.

We live in a divisive and crisis-burdened society. The insurance business, by its very nature, is heir to these problems. The private insurance business and the system of state regulation confront their greatest threat to survival in over 20 years. In the leadership of this Association we need a man of vision, ability and dedication to champion the cause of effective public regulation of the insurance business by the several states. And we need, above all else, men of principle, who are able to search out every avenue of reconciliation and accommodation of the divisions which threaten. Superintendent Stewart is a man of demonstrated ability and dedication and sincere desire, and nothing could be more important to the preservation of the state regulation of insurance than to have such a person among the leadership of this Association. At this time and this hour I recommend to you for election to the Chairmanship of the Executive Committee, the Hon. Richard E. Stewart, Superintendent of Insurance of the State of New York. Thank you. (Applause)

PRESIDENT BENTLEY: The Chair recognizes Mr. Kueckelhan.

COMMISSIONER KUECKELHAN: Mr. Chairman, I had hoped at this time to have presented another name for Chairmanship of the Executive Committee of this Association and I want to say that my

disappointment has been compensated for only by the fact that he is going to become a citizen of the State of Washington.

I think the things that have been said by the other two persons who presented Dick and the other things that we know about Dick make him an eminently qualified person to become the Chairman of the Executive Committee of this Association, and it is a real honor and pleasure for me to second Dick's name for this position. (Applause)

PRESIDENT BENTLEY: Thank you, Lee.

Are there other seconds to this nomination?

COMMISSIONER MONTGOMERY: Mr. President, it is a real delight for me to be able to second the nomination of Dick Stewart. Dick Stewart spent many years in our small State of West Virginia, where his father served as President of our State University. As a matter of fact, Dick was graduated from the University of West Virginia with the very highest scholastic average ever attained there. Dick Stewart has all the qualities and characteristics necessary to provide our organization with the kind of leadership which we need. Gentlemen, it is a delight for me to second Dick's nomination. (Applause)

PRESIDENT BENTLEY: Are there other seconds?

COMMISSIONER WALTON: Mr. Chairman, I note that the Commissioner from West Virginia lays claim to Dick Stewart, as I am sure the State of New York does. However, we in Wyoming lay claim to his most attractive wife, Sally. (Applause) We think that Dick's selection of Sally shows his good judgment and we know that if the State of New York runs the country, we have the State of Wyoming running the State of New York. (Laughter and applause) It gives me great pleasure to second the nomination of Dick Stewart of the State of New York. (Applause)

PRESIDENT BENTLEY: Are there other seconds?

COMMISSIONER PACK: Tennessee seconds the nomination of Dick Stewart.

COMMISSIONER WORTHINGTON: Iowa seconds the nomination of Dick Stewart.

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PRESIDENT BENTLEY: Are there any other seconds? Are there any other nominations for the office of Chairman of the Executive Committee?

COMMISSIONER MASTOS: Mr. President and gentlemen of the Executive Committee, members of the Association and ladies, it is a great privilege today for me to arise to speak for the second time for the nomination of a person distinguished within our organization to the office of Chairman of the Executive Committee. This is a gentleman that I have had the privilege of knowing in my tenure as Commissioner of not too many years — I am into my fourth year now — and Bob precedes me in the number of years of work and dedication to this organization. I have had the pleasure not only of working with him on committee assignments within this organization but the privilege of working with him in matters relative to the regulation of insurance, not only in my state but in the State of Wisconsin, in view of the nature of one of my major companies. I have found his counsel to be of great help to me in my short time within this organization. Bob is a very accomplished person, not only within our organization but within his own state. A graduate of the University of Wisconsin Law School in 1951, a Phi Beta Kappa, elected to the Order of the Coif, one of the highest orders within the law fraternity. He practiced law for 14 years, served for 11 years in the Wisconsin legislature, was Speaker of the Assembly, a majority party floor leader, minority party floor leader. He has lectured at the University of Wisconsin Law School and at the University School of Commerce for the past two years. He has served on the NAIC Executive Committee for the past two years. He has also seen action on many, many other NAIC committees and he has been Chairman of several important committees, such as Rates and Rating Organizations, and others. He was appointed by his Governor and confirmed by the Wisconsin Senate as Commissioner of Insurance until 1971, so that if he is elected as Chairman of the Executive Committee, he will be in a position to serve the NAIC for the next three years.

Commissioner Haase believes within the NAIC in full cooperation and coordination between all committees. He has the staff and the Department budget to enable him to do an outstanding job for our Association, as I said earlier, for the next three years, in the many and varied activities within our organization. Again, I consider it a real privilege and I am proud to nominate him for the office of Chairman of the Executive Committee. (Applause)

MR. O'BRIEN: Mr. Chairman and members of the Association, in behalf of the Director of Insurance of the State of Illinois, Chairman of Zone IV, I wish to add a few remarks in behalf of our sister State of Wisconsin Commissioner, Robert Haase. Commissioner Haase has demonstrated in a most exemplary manner the ability to assume difficult assignments and accomplish results. This is represented by his membership on many committees and subcommittees of the NAIC. He possesses the judicial temperament to avoid the unnecessary injection of disputes. For one thing, he has the courage and the voice to make his position



clear. I further submit to this assembly that they should give consideration to his proven record of leadership as demonstrated in the National Association of Insurance Commissioners and his activity in dealing with so many vital problems within this Association in considering him for election to the Chairmanship of the Executive Committee, which he is extremely well qualified to assume. And, as has been said, he is available until October, 1971. Therefore, it is my honor to second the nomination of Commissioner Haase, whose last name contains the letters of the words that very aptly describe his characteristics.

H is for one of his fine attributes, Helpfulness; A is for his ability and ableness; the second A is for his very active advocacy of state regulation of insurance; S stands for sincerity; and E stands for his energetic enthusiasm. He has served faithfully in the past and he will do so again as Chairman of the Executive Committee. Thank you. (Applause)

PRESIDENT BENTLEY: Are there any further seconds to his nomination?

SUPERINTENDENT HOUSEAL: Mr. President, I agree with Mr. O'Brien that simple attendance at this meeting affords ample display of the extraordinary talents which bob up. I know of no individual Commissioner who is endowed with more varied talents than Bob Haase. I think it is appropriate that we recognize these talents by his election to the Chairmanship of the Executive Committee, for which office I am honored to second his nomination.

And then I can't help but be impressed as I hear all about our shortcomings and the failures of NAIC, and I get a great deal of comfort from the statesmanship and ability displayed in the work Jim has done, the work that Charlie has done and will do, and all these extraordinarily able people, both young and old, who make up the membership of this organization, and I think that really we have more strengths than we do shortcomings. (Applause)

PRESIDENT BENTLEY: Thank you, Walter Houseal.

Are there other seconds?

Indiana seconds the nomination of Commissioner Haase.

Are there other seconds? Are there other nominations? If not, the Chair will declare the nominations closed and call on the tellers to circulate the ballots. Will you raise your hand, those who are entitled to vote, in order to expedite the election. It might expedite things if the gentlemen authorized to vote will move to the front.

PRESIDENT BENTLEY: Chairman Omholt, do you have a report?

COMMISSIONER OMHOLT: The State Auditor and Insurance Commissioner of the State of Montana, assisted by two other Commissioners, is pleased to report the following results of the election: 34 votes for Dick Stewart, Superintendent of Insurance of New York; 13 votes for Commissioner Haase of Wisconsin. Three states evidently abstained from voting.

PRESIDENT BENTLEY: I declare Dick Stewart elected as Chairman of the Executive Committee. (Applause)

COMMISSIONER HAASE: Mr. President, I would be very pleased at this time to move that the vote be made unanimous for Superintendent Stewart of New York and assure him that, as in the past, he and I are the very best of friends and we will be pleased to cooperate in the future. Thank you very much. (Applause) (Prolonged applause)

PRESIDENT BENTLEY: The Chair hears no objection to this motion to make the vote unanimous and declare Superintendent Stewart of New York unanimously elected Chairman of the Executive Committee of this Association. Congratulations, Dick. (Applause) (Applause as all stand)

SUPERINTENDENT STEWART: Well, thank you very much. I hope I can do a satisfactory job for you. I would especially like to thank both those friends who were kind enough to support me and those friends like Bob Haase and Walter Dell Davis, of different persuasion but who have conducted their campaign in the finest gentlemanly, generous fashion, and I want particularly to thank them for the way they have handled it and Bob for his gracious remarks. Thank you very, very much. (Applause)

PRESIDENT BENTLEY: Thank you, Dick. We can all be grateful that we have such excellent people competing for positions here in both of these gentlemen.

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PRESIDENT BENTLEY: The Chair now declares the floor open for nominations for the office of three seats at large on the Executive Committee.

COMMISSIONER MAXWELL: Mr. President and fellow members of the Association, I arise to nominate for at-large membership on the Executive Committee, Director Ben Neff of Nebraska. Last year at the NAIC meeting in Boston, our then President and friend, Frank

Barrett, introduced us to his successor as Director of Insurance of Nebraska. But before he did so, I was impressed with this gentleman because I was told that he was flying himself in in a jet airplane. Since I have met him and worked with him in this organization, my admiration and regard for Ben Neff has gone steadily upward and remained at a high peak. And he has never stopped moving in his service to this organization. He has attended every meeting of the Executive Committee in the last year even though he was not a member. He has accepted the Chairmanship of surely one of the most important subcommittees that we have in this organization, and I refer to the Subcommittee on Holding Companies, and he has taken the leadership in that Subcommittee to reach solutions for very difficult and complex problems that we as regulators face now in that field.

As the Director of Insurance in Nebraska, he heads a Department which has served the NAIC in numerous ways over the years, in various research and special projects that they have performed as well as, of course, the service of President Barrett.

I think that all of you know Ben Neff and I will not recite an obituary of his qualities, but you know that he is energetic and intelligent, that he is dedicated to this organization, and at a time when it has never been more important — and this has been said before, but it can't be said too often — that this organization function effectively in order to preserve state regulation, and I think that the membership of Ben Neff on the Executive Committee of this organization will give us added strength and help us to do the job that we should be doing. I hope you will support him. (Applause)

PRESIDENT BENTLEY: Thank you, Dave.

Are there seconds to this nomination?

COMMISSIONER WALTON: Mr. Chairman, speaking as Zone Chairman of Zone V, it gives me a great deal of pleasure, on behalf of the Zone V states, to second the nomination of Ben Neff of Nebraska.

PRESIDENT BENTLEY: Thank you.

Do you arise to second the nomination, Mr. Houseal?

SUPERINTENDENT HOUSEAL: As the world's foremost authority on Frank Barrett (Laughter), I think I cannot in good conscience sit here and not point out to you the tremendous strides forward that Nebraska took (Laughter) in the wise selection of his successor, and for this reason I am indeed delighted to second the nomination of Director Neff. (Applause)

PRESIDENT BENTLEY: Are there further seconds to this nomination?

COMMISSIONER WORTHINGTON: As a neighboring state and Commissioner who has had an opportunity to work very closely with Ben, it is my pleasure to also second his nomination.

PRESIDENT BENTLEY: Thank you, sir.

Are there other seconds to this nomination? Are there other nominations?

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COMMISSIONER PACK: Mr. President and members, it is my distinct pleasure to place in nomination at this time a man who is one of the deans of this organization, who has 16 years of service to NAIC. He has devoted himself to the affairs of this organization, loyally, diligently and competently. I think that the best interests of this Association not only make it appropriate that he serve on the Executive Committee but I think that the best interests of this Association demands that he serve on this Executive Committee, so that we will have his advice and counsel during the trying months ahead that we know we are going to face. Therefore with pride I place in nomination for a member of the Executive Committee-at-Large, Commissioner Walter Dell Davis of the State of Mississippi. (Applause)

PRESIDENT BENTLEY: Are there seconds to the nomination of Walter Dell Davis?

SUPERINTENDENT HOUSEAL: I certainly would not pass this opportunity to second the nomination of Commissioner Davis.

MR. FAIRCLOTH: Florida seconds the nomination of Commissioner Davis.

Louisiana seconds the nomination of Walter Dell Davis.

PRESIDENT BENTLEY: Are there other seconds? Are there other nominations?

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COMMISSIONER PRICE: President Bentley, we elect three members-at-large and one of the three is Dave Dykhouse, who serves presently on the Executive Committee. I hope he is one of the three. During the past year that I have been Chairman of the Executive Committee, I have leaned on Dave Dykhouse to assist me in solving some very difficult problems. I have found him to be loyal, devoted, in

my opinion a real asset to the Executive Committee, a man who makes a real contribution. You will not find anybody anywhere who will work harder on behalf of the NAIC than Dave Dykhouse, and it is my great privilege and pleasure to put his name in nomination for one of the three members-at-large on the Executive Committee. (Applause)

PRESIDENT BENTLEY: Thank you, Ned.

Are there seconds to this nomination?

COMMISSIONER WORTHINGTON: Mr. President, Iowa is proud to second the nomination of Dave Dykhouse.

COMMISSIONER DIRKS: South Dakota is proud to second the nomination of Dave Dykhouse.

COMMISSIONER OMHOLT: Montana is proud to second the nomination of Dave Dykhouse.

COMMISSIONER NYGAARD: North Dakota seconds the nomination of Dave Dykhouse.

PRESIDENT BENTLEY: Thank you, Commissioner. Are there other seconds to this nomination? Are there other nominations?

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COMMISSIONER KUECKELHAN: Yes, Mr. Chairman. We have a lot of talent in this organization and it makes it a little difficult. Zone VI has a man who we think will become a very valued member of the Executive Committee. He has had legislative investigative experience in his state. He has been a hard worker for this Association and I have been directed by Zone VI to present him as a candidate for at-large membership on the Executive Committee, and it is with a great deal of pride and pleasure and satisfaction that I present the name of your host Commissioner, James R. Faulstich of Oregon. (Applause)

PRESIDENT BENTLEY: Thank you, Commissioner.

Are there seconds to the nomination of our host commissioner?

COMMISSIONER BARNES: Colorado seconds his nomination.

COMMISSIONER KNOWLTON: New Hampshire seconds.

COMMISSIONER HONDA: The Aloha State wishes to join in seconding the nomination of our host Commissioner, James R. Faulstich.

MR. ZAHN: Oklahoma seconds.

COMMISSIONER FRITZ: Alaska, the largest state in the United States, seconds the nomination. (Laughter)

COMMISSIONER PETRARCA: The smallest state in the United States also seconds the nomination.

PRESIDENT BENTLEY: Are there other seconds to this nomination?

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Are there other nominations, gentlemen?

COMMISSIONER MONTGOMERY: Mr. President, it is indeed a delight for me to nominate Commissioner Edwin Lanier of North Carolina for membership on the Executive Committee. Ed. Lanier was born in Georgia, he went to the University of North Carolina to attend college and he stayed there for many, many years. As a matter of fact, he has taught at the University of North Carolina and served there for some 28 years as a student aid officer.

Commissioner Lanier has been active in his political party. He is a dedicated and experienced public servant. He served as Mayor of Chapel Hill and on the County Board of Commissioners and several terms in the North Carolina State Senate. Ed. was appointed Commissioner of Insurance in 1962, was successively elected for two-year terms and is currently serving a four-year term. Commissioner Lanier has been quite active in the affairs of this organization. I submit to you that Commissioner Lanier has the maturity, worth, judgment and experience to do an outstanding job on our Executive Committee. (Applause)

MR. CLARK: Mr. Chairman, it is with pride and genuine affection that South Carolina arises to second the nomination of the Commissioner of a sister state. His well-known qualities are universally recognized but the lateness of the hour leads me to forego any extended discussion. We do heartily second his nomination.

PRESIDENT BENTLEY: Thank you, Howard.

Are there any other seconds to this nomination?

MR. J. H. PARKER: Virginia wishes to second the nomination.

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PRESIDENT BENTLEY: Thank you. Any other seconds to this nomination?

Are there other nominations for the seats-at-large on the Executive

Committee? Gentlemen, we have three vacancies on this Committee. Nominated are Benjamin Neff of Nebraska, Walter Dell Davis of Mississippi, David Dykhouse of Michigan, James Faulstich of Oregon, and Ed. Lanier of the State of North Carolina. You are instructed to vote for three of these gentlemen. The three Commissioners receiving the highest number of votes are elected to seats-at-large on the Executive Committee. The polls are closed; the ballots are open.

COMMISSIONER OMHOLT: Commissioner Bentley, the committee is pleased to report that of the 47 states voting, Ben Neff, Dave Dykhouse and James Faulstich received the greatest number of votes.

PRESIDENT BENTLEY: The Chair declares the three members of the states named at-large members of the Executive Committee, Commissioners Dykhouse, Faulstich and Neff. Congratulations, gentlemen. (Applause)

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PRESIDENT BENTLEY: Would the zone chairmen give us some additional information on the zone officers, the zone chairmen and members of the Executive Committee. Gene Farnam is not here. Is there anyone can report for Zone I?

MR. HOWARTH: I am George Howarth of the Massachusetts Insurance Department. I am happy to give you the returns of the election of Zone I, as follows: Frank M. Hogerty, Jr., Insurance Commissioner of Maine, Chairman of Zone I; C. Eugene Farnam, Commissioner of Insurance of Massachusetts, member of the Executive Committee.

PRESIDENT BENTLEY: Thank you George.

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Zone II, Frank Montgomery.

COMMISSIONER MONTGOMERY: Mr. President, the newly-elected officers of Zone II are as follows: Chairman, Robert Short of Delaware; Vice-Chairman, Commissioner Steers of Maryland; zone representative on the Executive Committee, David Maxwell of Pennsylvania. And John Coppage of Maryland is our Chaplain. (Laughter)

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PRESIDENT BENTLEY: Dave Pack for Zone III.

COMMISSIONER PACK: Mr. President, for Zone III Commissioner Robert Scharz of the State of Missouri will serve as Zone

Chairman; and Commissioner Broward Williams of the State of Florida will serve on the Executive Committee.

**PRESIDENT BENTLEY:** No chaplain in Zone III. We don't need one down South!

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John Bolton of Illinois for Zone IV.

**MR. O'BRIEN:** John Bolton of Illinois was re-elected Chairman of Zone IV; Commissioner Lorne Worthington of Iowa was elected its representative on the Executive Committee.

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**PRESIDENT BENTLEY:** Commissioner Walton, may we have your report?

**COMMISSIONER WALTON:** Mr. Chairman, at the regular Zone V meeting held in Jackson, Wyoming, in March, Director Ben Neff of Nebraska was elected Chairman of Zone V and, of course, in line with our usual practice, he will also serve as our zone representative on the Examinations Committee. At the Portland meeting we have elected Frank Sullivan as Vice-Chairman of our zone, and Commissioner Walton of Wyoming as the representative on the Executive Committee. I think Ralph Apodaca is our Tail Twister.

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**PRESIDENT BENTLEY:** Lee Kueckelhan.

**COMMISSIONER KUECKELHAN:** Zone VI elected Elmer V. "Sonny" Omholt as Chairman and Louis T. Mastos of Nevada as our representative on the Executive Committee. We had 10 candidates for Vice-Chairman and decided to defer the election until we have a zone meeting in Boise this Fall. (Laughter)

**PRESIDENT BENTLEY:** Thank you very much, Lee.

Now that Commissioner Omholt has been released from his auditing functions, will the members of the various zone chairmen meet here briefly. Would it be possible for you to name a Chairman and a Vice Chairman from your ranks of the Examinations Committee? This should be done. I don't know that it is necessary for this session to continue. You gentlemen can do this following the adjournment of this session, but it should be done today. It can be done immediately and that information filed with Mr. Tollack.

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**Note 1:** To complete the Meeting record, the members of the Examinations Committee (NAIC Zone Chairmen) elected the Honorable John F. Bolton, Jr., Illinois, Chairman and the Honorable Elmer V. Omholt, Montana, Vice Chairman.

**Note 2:** A copy of the Report of NAIC Election Results published during the Portland Meeting follows.



NAIC ELECTION RESULTS

Ref: NAIC CONSTITUTION, 1968 Proc. VOL. I pp. 2-4

1968 ANNUAL MEETING

PORTLAND, OREGON

JUNE 16-21, 1968

OFFICERS

(and Ex-officio Members of Executive Committee)

Ref: NAIC Constitution Articles 5 and 6

CHARLES R. HOWELL, PRESIDENT	NEW JERSEY
NED PRICE, VICE PRESIDENT	TEXAS
RALPH F. APODACA, ACTG. SECRETARY-TREASURER	NEW MEXICO

EXECUTIVE COMMITTEE

Ref: NAIC Constitution Article 6

RICHARD E. STEWART, CHAIRMAN	NEW YORK
JAMES L. BENTLEY, VICE CHAIRMAN	GEORGIA
DAVID J. DYKHOUSE	MICHIGAN
BENJAMIN C. NEFF, JR.	NEBRASKA
JAMES R. FAULSTICH	OREGON
C. EUGENE FARNAM	ZONE 1 MASSACHUSETTS
DAVID O. MAXWELL	ZONE 2 PENNSYLVANIA
BROWARD WILLIAMS	ZONE 3 FLORIDA
LORNE R. WORTHINGTON	ZONE 4 IOWA
WILLIAM G. WALTON	ZONE 5 WYOMING
LOUIS T. MASTOS	ZONE 6 NEVADA

\*EXAMINATIONS COMMITTEE

Ref: NAIC Constitution Article 6

JOHN F. BOLTON, JR., CHAIRMAN	ZONE 4 ILLINOIS
ELMER V. OMHOLT, VICE CHAIRMAN	ZONE 6 MONTANA
FRANK M. HOGERTY, JR.	ZONE 1 MAINE
ROBERT A. SHORT	ZONE 2 DELAWARE
ROBERT D. SCHARZ	ZONE 3 MISSOURI
BENJAMIN C. NEFF, JR.	ZONE 5 NEBRASKA

\*ZONE CHAIRMEN comprise the Membership of EXAMINATIONS COMMITTEE.

**PRESIDENT BENTLEY:** Is there any other business to be conducted or any other information to be submitted to this meeting on the California session in December? Dick Roddis, did you have any further comments to make on the Los Angeles meeting?

**COMMISSIONER RODDIS:** Well, of course, we look forward to welcoming you all in Los Angeles in December. I think you will find it will be a fine convention. The headquarters hotel is the Century Plaza, which is one of the beautiful new hotels in the United States and it has some of the best convention facilities I have ever seen. We have had a substantial number of people up here at this convention from our convention host committee. They have benefited a great deal from their observations of the excellence with which this convention has been conducted and organized and I think that, benefiting from that experience, it will be of assistance to them. We have had a booth open here throughout the convention, staffed with some of our people. I urge all of you to fill out the registration forms and send them in at the earliest opportunity so that room and suite assignments may be effected.

I also urge you to, if you have not done so before, fill out the questionnaire which is included in the pamphlet and I think also copies are available at the booth, as to the attractions in the Los Angeles area in which you might be most interested, because, as you know, the Los Angeles area is somewhat dispersed and many of these attractions are some distance away, and it is our desire to not only make available, transportation and tickets to the various attractions, but to do this we need to know in advance what people's interests are, get somewhat of a poll on those matters. So I urge you to send those questionnaires in.

As I indicated earlier, I will not be there to host you, but I can assure you that the State of California and all of its public officials and all of its domestic industry will extend you the warmest greetings and that you will find it a pleasant and I hope attractive and productive meeting of the Association. Thank you.

**COMMISSIONER HOUSEAL:** Mr. President, I am going to suggest that when Commissioner Roddis writes the letters inviting the other national regulatory authorities to attend the meeting, he also write one to himself, in our behalf.

**PRESIDENT BENTLEY:** We'll be delighted to have you with us, Dick.

Are there any other announcements to be made? Is there any need on the part of the Commissioners to meet secretly on the part of only the membership of this Association? We have this as an item on the agenda. We have met and we have extended this item on the agenda.

Does any Commissioner have any reason for an exclusive session of Commissioners today? If not, we will consider that item later on.

COMMISSIONER APODACA: It seems something very important happened at this meeting and I have to lay all credit for it to Walter Houseal from Alabama. The Mexico Insurance Problems Committee, as you all know, was abolished in name and a new committee was created with International scope. Our next stop is going to be in Madrid. (Laughter) Maybe Walter will want to explain a little further how we are going to finance it there.

COMMISSIONER HOUSEAL: No, sir. I'm going to see if I am reappointed on my committee before I divulge my plans. (Laughter)

PRESIDENT BENTLEY: It appears now we have run the full gauntlet. We have a Committee on State Liaison, a Committee on Federal Liaison, and now we have an International Committee on Liaison. We've got no worries now!

Does anyone have any other announcements that we may anticipate? We might remind the Commissioners that this Committee on Automobile Insurance has been designated now and any Commissioner who is invited to testify in Washington before any of these committees can find a great deal of information, hopefully, from this Committee, but certainly from our counsel in Washington, who has already accumulated files and already has considerable expertise in this area. And we now have our research technician, so we have three sources of information. Anyone who is invited, we would certainly hope that he would file copies of his statement with NAIC for the development of our own files here and what Commissioners have said.

There is another announcement here that should be made. There will be a reception on the Pavilion at the plaza level between the hours of 2:00 and 4:00 for all incoming leaders. (Signed) Howell. (Applause)

Is there any other business? If not, gentlemen, thank you and I declare this meeting of NAIC adjourned.

. . . Adjourned at 1:30 P.M. . . .

## MEETING RECORD

The following is a Record of Officers and list of Places at which the National Association of Insurance Commissioners has been held since its organization.

Session	Place of Meeting	President	Vice-President	Secretary
1, 1871	New York, N. Y.	Geo. W. Miller, N. Y.	L. Breeze, Wis.	H. S. Olcott, N. Y.
2, 1871	New York, N. Y.	Geo. W. Miller, N. Y.	L. Breeze, Wis.	H. S. Olcott, N. Y.
3, 1872	New York, N. Y.	Geo. W. Miller, N. Y.	L. Breeze, Wis.	H. S. Olcott, N. Y.
4, 1873	Boston, Mass.	L. Breeze, Wis.	J. W. Foard, Calif.	O. Pillsbury, N. H.
5, 1874	Detroit, Mich.	O. W. Chapman, N. Y.	S. H. Rowe, Mich.	O. Pillsbury, N. H.
6, 1875	New York, N. Y.	O. W. Chapman, N. Y.	S. H. Rowe, Mich.	O. Pillsbury, N. H.
7, 1876	Harrisburg, Pa.	S. H. Rowe, Mich.	O. Pillsbury, N. H.	S. H. Rhodes, Mass.
8, 1877	St. Paul, Minn.	S. H. Rowe, Mich.	O. Pillsbury, N. H.	S. H. Rhodes, Mass.
9, 1878	Providence, R. I.	O. Pillsbury, N. H.	A. R. McGill, Minn.	O. T. Welch, Kans.
10, 1879	St. Louis, Mo.	O. Pillsbury, N. H.	A. R. McGill, Minn.	O. T. Welch, Kans.
11, 1880	Chicago, Ill.	A. R. McGill, Minn.	J. L. Clarke, Mass.	O. T. Welch, Kans.
12, 1881	Detroit, Mich.	J. L. Clarke, Mass.	J. L. Clarke, Mass.	O. T. Welch, Kans.
13, 1882	Niagara Falls, N. Y.	J. L. Clarke, Mass.	P. L. Spooner, Wis.	O. T. Welch, Kans.
14, 1883	Columbus, Ohio	O. Pillsbury, N. H.	A. J. McCall, Jr., N. Y.	O. T. Welch, Kans.
15, 1884	Chicago, Ill.	J. A. McCall, Jr., N. Y.	C. P. Swigert, Ill.	J. W. Brooks, Conn.
16, 1885	Chicago, Ill.	J. A. McCall, Jr., N. Y.	C. H. Moore, Ohio	C. P. Swigert, Ill.
17, 1886	St. Paul, Minn.	C. P. Swigert, Ill.	E. Pringle, Mich.	C. P. Swigert, Ill.
18, 1887	Niagara Falls, N. Y.	J. K. Tarbox, Mass. 1	H. J. Reinmund, Ohio	C. Shandrew, Minn.
19, 1888	Madison, Wis.	Philip Cheek, Jr., Wis.	S. H. Cross, R. I.	R. B. Brinkerhoff, Ohio
20, 1889	Denver, Colo.	O. R. Fyler, Conn.	O. R. Fyler, Conn.	J. A. McEwen, Ohio
21, 1890	Cleveland, Ohio	Geo. S. Merrill, Mass.	S. E. Kemp, Ohio	Geo. B. Luper, Pa.
22, 1891	St. Louis, Mo.	C. P. Ellerbe, Mo.	S. E. Kemp, Ohio	Geo. B. Luper, Pa.
23, 1892	St. Paul, Minn.	Geo. B. Luper, Pa.	Geo. E. Luper, Pa.	Chas. B. Allen, Neb. 2
24, 1893	Chicago, Ill.	John C. Linehan, N. H.	Wm. H. Kinder, Ohio	J. J. Brinkerhoff, Ill.
25, 1894	Alexandria Bay, N. Y.	Jas. F. Pierce, N. Y.	C. N. Smith, Minn.	J. J. Brinkerhoff, Ill.
26, 1895	Mackinac Isl., Mich.	B. K. Durfee, Ill.	B. K. Durfee, Ill.	J. J. Brinkerhoff, Ill.
27, 1896	Philadelphia, Pa.	W. M. Hahn, Ohio, 3	W. M. Hahn, Ohio	Fred L. Cutting, Mass.
28, 1897	Old Pt. Comfort, Va.	Jas. R. Waddill, Mo., 4	Jas. R. Waddill, Mo.	Fred L. Cutting, Mass.
29, 1898	Milwaukee, Wis.	Stephen W. Carr, Maine	Stephen W. Carr, Maine	Fred L. Cutting, Mass., 5
30, 1899	Detroit, Mich.	Elmer H. Dearth, Minn., 7	W. A. Fricke, Wis.	Fred L. Cutting, Mass., 6
31, 1900	Hartford, Conn.	Ed. T. Orear, Mo.	Milo D. Campbell, Mich.	J. J. Brinkerhoff, Ill.
32, 1901	Buffalo, N. Y.	J. A. O. Shaughnessy, Minn., 8	W. S. Matthews, Ohio	J. J. Brinkerhoff, Ill.
33, 1902	Columbus, Ohio	W. H. Hart, Ind.	E. L. Scofield, Conn.	J. J. Brinkerhoff, Ill.
34, 1903	Baltimore, Md.	A. I. Vorys, Ohio	F. A. Howland, Vt.	J. J. Brinkerhoff, Ill.
35, 1904	Indianapolis, Ind.	John L. Bacon, Vt.	John L. Bacon, Vt.	J. J. Brinkerhoff, Ill.
36, 1905	Bretton Woods, N. H.	Frederick L. Cutting, Mass.	James V. Barry, Mich.	J. J. Brinkerhoff, Ill.
37, 1906	Washington, D. C.	James V. Barry, Mich.	James V. Barry, Mich.	J. J. Brinkerhoff, Ill.
38, 1907	Richmond, Va.	Geo. H. Adams, N. H.	Theron Upson, Conn.	J. J. Brinkerhoff, Ill.
39, 1908	Detroit, Mich.	Reau E. Folk, Tenn.	Reau E. Folk, Tenn.	J. J. Brinkerhoff, Ill.
40, 1909	Colorado Spgs., Colo.	B. F. Crouse, Md.	B. F. Carroll, Iowa	J. J. Brinkerhoff, Ill.
41, 1910	Mobile, Ala.	John A. Hartigan, Minn.	F. W. Potter, Ill.	J. A. Hartigan, Minn.
42, 1911	Milwaukee, Wis.	Joseph Button, Va.	Eugene J. McGivney, La.	H. R. Cunningham, Mont.
43, 1912	Spokane, Wash.	F. W. Potter, Ill.	T. H. Macdonald, Conn., 9	H. R. Cunningham, Mont.
			Frank H. Hardison, Mass.	F. H. McMaster, S. C. 10

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MEETING RECORD—Continued

Session	Place of Meeting	President	Vice-President	Secretary
44, 1913	Burlington, Vt. -----	Frank H. Hardison, Mass. -----	1st. James R. Young, N. C. ----- 2d. Willard Done, Utah -----	F. F. McMaster, S. C.
45, 1914	Asheville, N. C. -----	James R. Young, N. C. -----	1st. Willard Done, Utah, 11 ----- 2d. J. S. Darst, W. Va. -----	F. H. McMaster, S. C.
46, 1915	Del Monte, Calif. -----	John S. Darst, W. Va. -----	1st. Burton Mansfield, Conn. ----- 2d. John T. Winship, Mich. -----	F. H. McMaster, S. C.
47, 1916	Richmond, Va. -----	Burton Mansfield, Conn. -----	1st. John T. Winship, Mich. ----- 2d. W. C. Taylor, N. Dakota -----	F. H. McMaster, S. C.
48, 1917	St. Paul, Minn. -----	Jesse S. Phillips, N. Y. -----	1st. John T. Winship, Mich. ----- 2d. Emory H. English, Iowa -----	F. H. McMaster, S. C.
49, 1918	Denver, Colo. -----	Emory H. English, Iowa, 12 -----	1st. Robt. J. Merrill, N. H., 13 ----- 2d. M. J. Cleary, Wis., 14 -----	F. H. McMaster, S. C., 15
50, 1919	Hartford, Conn. -----	C. W. Fairchild, Colo. -----	1st. Jos. G. Brown, Vt. ----- 2d. Frank H. Ellsworth, Mich. -----	Joseph Button, Va.
51, 1920	Beverly Hills, Calif. -----	Jos. G. Brown, Vt. -----	1st. F. H. Ellsworth, Mich. ----- 2d. J. E. Sanborn, Minn., 16 -----	Joseph Button, Va.
52, 1921	Louisville, Ky. -----	F. H. Ellsworth, Mich., 17 -----	1st. A. L. Harty, Mo., 18 ----- 2d. T. B. Donaldson, Penn., 19 -----	Joseph Button, Va.
53, 1922	Swampscott, Mass. -----	Thos. B. Donaldson, Pa. -----	1st. Platt Whitman, Wis. ----- 1st. H. O. Fishback, Wash., 21 -----	Joseph Button, Va.
54, 1923	Minneapolis, Minn. -----	Platt Whitman, Wis., 20 -----	1st. H. O. Fishback, Wash. ----- 2d. J. C. Luning, Fla., 22 -----	Joseph Button, Va.
55, 1924	Seattle, Wash. -----	H. O. Fishback, Wash. -----	1st. J. C. Luning, Fla. ----- 2d. S. W. McCulloch, Penn. -----	Joseph Button, Va.
56, 1925	San Antonio, Texas -----	J. C. Luning, Fla. -----	1st. S. W. McCulloch, Penn. ----- 2d. E. T. Bullion, Ark. -----	Joseph Button, Va.
57, 1926	Los Angeles, Calif. -----	W. R. Kendrick, Iowa, 23 -----	1st. T. M. Henry, Miss. ----- 2d. T. M. Baldwin, D. C. -----	Joseph Button, Va.
58, 1927	Cincinnati, Ohio -----	Harry L. Conn, Ohio, 24 -----	1st. A. S. Caldwell, Tenn. ----- 2d. C. R. Detrick, Calif. -----	Joseph Button, Va.
59, 1928	Rapid City, S. D. -----	A. S. Caldwell, Tenn. -----	1st. C. R. Detrick, Calif. ----- 2d. James A. Beha, N. Y. -----	Joseph Button, Va.
60, 1929	Toronto, Canada -----	C. R. Detrick, Calif., 25 -----	1st. James A. Beha, N. Y., 26 ----- 2d. H. P. Dunham, Conn., 27 -----	Joseph Button, Va.
61, 1930	Hartford, Conn. -----	H. P. Dunham, Conn. -----	1st. C. C. Wysong, Ind., 28 ----- 2d. Jess G. Read, Okla. -----	A. S. Caldwell, Tenn.
61, 1930	Hartford, Conn. -----	C. C. Wysong, Ind., 29 -----	1st. Jess G. Read, Okla. ----- 2d. Clare A. Lee, Ore., 30 -----	A. S. Caldwell, Tenn.
62, 1931	Portland, Ore. -----	Jess G. Read, Okla., 31 -----	1st. C. D. Livingston, Mich., 32 ----- 2d. W. A. Tarver, Tex., 33 -----	A. S. Caldwell, Tenn.
63, 1932	Dallas, Texas -----	Chas. D. Livingston, Mich. -----	1st. W. A. Tarver, Texas ----- 2d. Garfield W. Brown, Minn. -----	Jess G. Read, Okla.
63, 1932	Dallas, Texas -----	W. A. Tarver, Tex., 34 -----	1st. Garfield W. Brown, Minn. ----- 2d. Dan C. Boney, N. C. -----	Jess G. Read, Okla.
64, 1933	Chicago, Ill. -----	Garfield W. Brown, Minn. -----	1st. Dan C. Boney, N. C. ----- 1st. Geo. S. Van Schaick, N. Y. -----	Jess G. Read, Okla.
65, 1934	St. Petersburg, Fla. -----	Garfield W. Brown, Minn. -----	1st. Dan C. Boney, N. C. ----- 2d. Geo. S. Van Schaick, N. Y. -----	Jess G. Read, Okla.

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Session	Place of Meeting	President	Vice-President	Secretary
66, 1935	Seattle, Wash.	Dan C. Boney, N. C.	1st. Geo. S. Van Schaick, N. Y.	Jess G. Read, Okla.
67, 1936	St. Paul, Minn.	Wm. A. Sullivan, Wash.	2d. Merton L. Brown, Mass.	Jess G. Read, Okla.
68, 1937	Philadelphia, Pa.	Ernest Palmer, Ill.	1st. Ernest Palmer, Ill.	Jess G. Read, Okla.
69, 1938	Quebec, Canada	George A. Bowles, Va.	2d. Geo. A. Bowles, Va.	Jess G. Read, Okla.
70, 1939	San Francisco, Calif.	Frank N. Julian, Ala.	George A. Bowles, Va.	Jess G. Read, Okla.
71, 1940	Hartford, Conn.	C. Clarence Neslen, Utah	Sam L. Carpenter, Jr., Cal., 35	Jess G. Read, Okla.
72, 1941	Detroit, Mich.	John C. Blackall, Conn.	Arthur J. Ham, Wyoming	Jess G. Read, Okla.
73, 1942	Denver, Colo.	Charles Hobbs, Kansas	John C. Blackall, Conn.	Jess G. Read, Okla.
74, 1943	Boston, Mass.	John Sharpe Williams III, Miss.	Charles Hobbs, Kansas	Jess G. Read, Okla.
75, 1944	Chicago, Ill.	C. F. J. Harrington, Mass.	John Sharpe Williams III, Miss.	Jess G. Read, Okla.
76, 1945	St. Paul, Minn.	Newell R. Johnson, Minn.	C. F. J. Harrington, Mass.	Jess G. Read, Okla.
77, 1946	Portland, Ore.	James M. McCormack, Tenn.	Newell R. Johnson, Minn.	Jess G. Read, Okla.
78, 1947	Atlantic City, N. J.	Robert E. Dineen, N. Y.	James M. McCormack, Tenn.	Jess G. Read, Okla.
79, 1948	Philadelphia, Pa.	Seth B. Thompson, Ore.	Edward L. Scheufler, Mo., 36	Jess G. Read, Okla., 37
80, 1949	Seattle, Wash.	J. Edwin Larson, Fla.	Robert E. Dineen, N. Y.	N. P. Parkinson, Ill., 38
81, 1950	Quebec, P.Q., Canada	David A. Forbes, Mich.	Seth B. Thompson, Ore.	William P. Hodges, N. C.
82, 1951	Swampscott, Mass.	W. Ellery Allyn, Conn.	J. Edwin Larson, Fla.	William P. Hodges, N. C.
83, 1952	Chicago, Ill.	Frank Sullivan, Kans.	David A. Forbes, Mich.	George A. Bowles, Va.
84, 1953	San Francisco, Calif.	Wade O. Martin, Jr., La.	W. Ellery Allyn, Conn.	George A. Bowles, Va.
85, 1954	Detroit, Mich.	D. D. Murphy, S. C.	Frank Sullivan, Kans.	George A. Bowles, Va.
86, 1955	Los Angeles, Calif.	Donald Knowlton, N. H.	Wade O. Martin, Jr., La.	George A. Bowles, Va.
87, 1956	St. Louis, Mo.	C. Lawrence Leggett, Mo.	D. D. Murphy, S. C.	George A. Bowles, Va.
88, 1957	Atlantic City, N. J.	Robert B. Taylor, Ore.	Donald Knowlton, N. H., 39	George A. Bowles, Va.
89, 1958	Chicago, Ill.	Joseph A. Navarre, Mich.	C. Lawrence Leggett, Mo.	George A. Bowles, Va.
90, 1959	Boston, Mass.	Paul A. Hammel, Nev., 40	Robert B. Taylor, Ore.	George A. Bowles, Va.
91, 1960	San Francisco, Calif.	Sam N. Beery, Colo.	Joseph A. Navarre, Mich.	Paul A. Hammel, Nev.
92, 1961	Philadelphia, Pa.	Sam N. Beery, Colo.	Arch E. Northington, Tenn.	J. Edwin Larson, Fla.
93, 1962	Dallas, Texas, 42	T. Nelson Parker, Va.	Sam N. Beery, Colo., 41	J. Edwin Larson, Fla.
94, 1963	Montreal, Canada	T. Nelson Parker, Va.	Sam N. Beery, Colo.	Alfred N. Premo, Conn.
95, 1964	Chicago, Ill.	Rufus D. Hayes, La.	T. Nelson Parker, Va.	Alfred N. Premo, Conn.
96, 1965	Seattle, Wash.	Rufus D. Hayes, La.	Rufus D. Hayes, La.	Harvey G. Combs, Ark.
1966	Phoenix, Ariz.	Lee I. Kueckelhan, Wash.	Joseph S. Gerber, Ill.	Harvey G. Combs, Ark.
1967	Minneapolis, Minn.	Lee I. Kueckelhan, Wash.	Cyrus E. Magnusson, Minn.	Harvey G. Combs, Ark.
1968	Las Vegas, Nev.	Cyrus E. Magnusson, Minn.	Cyrus E. Magnusson, Minn.	Ralph F. Apodaca, N. M.
1969	New York, N. Y.	Cyrus E. Magnusson, Minn.	William E. Timmons, Iowa	Ralph F. Apodaca, N. M.
1970	Miami Beach, Fla.	William E. Timmons, Iowa	William E. Timmons, Iowa	Ralph F. Apodaca, N. M.
1971	Richmond, Va., 44	William E. Timmons, Iowa	Frank J. Barrett, Neb.	Ralph F. Apodaca, N. M.
1972	Dallas, Texas	Frank J. Barrett, Neb.	Frank J. Barrett, Neb.	Ralph F. Apodaca, N. M.
1973	Boston, Mass., 44	Frank J. Barrett, Neb.	James L. Bentley, Ga.	Ralph F. Apodaca, N. M.
1974	Honolulu, Hawaii	James L. Bentley, Ga.	James L. Bentley, Ga.	Ralph F. Apodaca, N. M.
1975	Portland, Oregon	James L. Bentley, Ga.	Charles R. Howell, N. J.	Ralph F. Apodaca, N. M.
1976			Charles R. Howell, N. J.	Ralph F. Apodaca, N. M., 43

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1. Mr. Tarbox died before the Convention assembled. The Hon. Oliver Pillsbury, of New Hampshire, was chosen to preside over the Convention.
2. Elected, but resigned before acting in Convention in 1891, and J. J. Brinkerhoff, of Illinois, was chosen in his stead.
3. Out of office at date of Convention, Jas. R. Waddill, of Missouri, elected to preside.
4. Out of office at date of Convention, Stephen W. Carr, of Maine, elected to preside.
5. Not in attendance, J. J. Brinkerhoff chosen as Secretary pro tem.
6. Elected, but declined. J. J. Brinkerhoff chosen in his stead.
7. Out of office at date of Convention, Ed. T. Orear, of Missouri, elected to preside.
8. Out of office at date of Convention, W. H. Hart, of Indiana, elected to preside.
9. Elected at Mobile, but out of office at date of Milwaukee Convention. Vacancy not filled until general election.
10. Elected in March, 1912, to succeed Mr. Cunningham, who had resigned.
11. Elected, but resigned before acting in Convention.
12. Elected, but resigned in January, 1918.
13. Elected, but resigned in November, 1917.
14. Elected 1st Vice-President at adjourned meeting in December, 1917, to succeed R. J. Merrill, resigned and elected President by the Executive Committee in January, 1918. Presided at Denver, 1918.
15. Elected, but resigned in December, 1917, Joseph Button, of Virginia, elected, at adjourned meeting in December, 1917.
16. Elected, but resigned in June, 1920.
17. Elected, but resigned in June, 1921.
18. Elected President by the Executive Committee in June, 1921. Presided at Louisville, 1921.
19. Elected First Vice-President by the Executive Committee in June, 1921.
20. Elected, but resigned July 1, 1923.
21. Elected President by Executive Committee in July, 1923. Presided at Minneapolis, 1923.
22. Elected First Vice-President by Executive Committee in July, 1923.
23. Elected, but resigned in January, 1926, and Harry L. Conn, Ohio, was elected in his stead and presided at Los Angeles.
24. Elected, but resigned in April, 1927, and A. S. Caldwell was elected in his stead and presided at Cincinnati.
25. Elected, but resigned in April, 1929.
26. Resigned January 1, 1929.
27. Elected First Vice-President and then President and presided at Toronto.
28. C. C. Wyson, Ind., elected First Vice-President and Jess G. Read, Okla., Second Vice-President.
29. Elected President at Hartford, 1930. Resigned in January, 1931.
30. Elected Second Vice-President at Hartford, 1930. Served until early part of 1931.
31. Elected President by Executive Committee in January, 1931.
32. Elected by Executive Committee in 1931.
33. Elected by Executive Committee in 1931.
34. Elected at Dallas in 1932 and served until early in 1933.
35. Elected at Philadelphia, Pa., in 1937. Resigned early in 1938.
36. Resigned October, 1945.
37. Died July 20, 1946.
38. Elected by Executive Committee, September, 1946.
39. Elected by Executive Committee, December 1953—See 1954 Volume I, page 53.
40. Elected by Executive Committee Jan., 1959, following resignation of President Arch H. Northington, Tenn.
41. Elected by Executive Committee Jan., 1959.
42. Regular meeting—Ref.: 1961 Proc. VOL. I page 42.
43. Elected Acting Secretary — Ref: 1965 Proceedings Vol. II page 658.
44. Numbering Annual Meetings discontinued. Ref: 1966 Proceedings Vol. I page 48.

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