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3. To make state insurance departments more aware of insurance regulatory research efforts;
4. To increase the rigor, quality and quantity of the research efforts on insurance regulatory issues; and
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Editors’ Perspective

Reigniting the Insurance Redlining Debate?

Gregory D. Squires

Insurance redlining is not the heated public policy issue it was just 10 short years ago. At that time, Congress was considering a disclosure rule that would have brought the kind of “sunshine” to the property insurance industry that the Home Mortgage Disclosure Act brought to mortgage lending. The absence of such debate today reflects, in part, changes that occurred because of the advocacy of non-profit fair housing organizations. But, according to the author, evidence suggests that redlining may be making a “comeback.” Two related articles in this issue of the JIR constitute a small but important step in what the author hopes will become a broader public discussion of this re-emerging phenomenon.
Do Home Insurance Base Premium-Setting Policies Create Disparate Racial Impacts? The Case of Large Insurance Companies in Ohio

George Galster

Analyzing an unusual dataset acquired by the Ohio Civil Rights Commission from six large home insurers operating in Ohio, this study investigates the degree to which black, Hispanic and non-Hispanic white homeowners face different base premium rates, on average, based on where they reside in the state. The evidence shows that, from a statewide perspective, there is no consistent pattern of minority homeowners disproportionately living in areas with substantially higher base premiums, though results vary by company.

The Potential for Racial Discrimination by Homeowners Insurers Through the Use of Geographic Rating Territories

Stephen M. Dane

This paper discusses the potential racial implications of using geographic rating territories in the homeowners insurance rating process. Specifically, the paper addresses a homeowners insurer’s potential exposure to legal liability under the federal Fair Housing Act by the use of geographic rating territories to determine rates. The paper also discusses a recent study on homeowners insurance in Ohio, highlighting the study’s limitations as a tool to determine whether insurers’ practices are the result of prohibited discrimination.

Racial Profiling, Insurance Style

Gregory D. Squires
Charis E. Kurbrin

This article is a reprint of Chapter 4 from Privileged Places: Residence, and the Structure of Opportunity, by Gregory D. Squires and Charis E. Kurbrin.

*John Robst*

A 2001 Weiss Ratings study reported that premiums for plans that cover prescription drugs increased 37.2%, while premiums for plans without prescription benefits increased 15.5%. However, the computation of average premiums did not take into account the market share of the insurers. This paper weights premium growth by Medigap plan enrollment to account for market share, then re-examines premium growth between 1998 and 2000 for Medigap supplemental insurance coverage.

Health Insurance Regulation by the States and the Federal Government: A Review of Current Regulation and Proposals for Change

*Mila Kofman, J.D.*
*Karen Pollitz, M.P.P.*

This paper provides an overview of the current regulation of health insurance, including a discussion of state and federal standards, regulation and oversight. It then reviews three Congressional proposals to change health insurance regulation, largely by altering the current balance of federal and state regulatory roles.

**Legal Reviews**

Significant Insurance Litigation Post-Hurricane Katrina

*Kara D. Binderup, J.D.*

Guidelines for Authors
Editors’ Perspective

As regulators and policymakers face challenges in how to effectively regulate an evolving marketplace, with new products and business practices evolving at record speed, we have decided to devote a portion of this issue of the Journal of Insurance Regulation to exploring a topic that has been the subject of ongoing public policy debates: race and insurance.

To that end, there are four articles on the subject. In “Reigniting the Insurance Redlining Debate?” Professor Gregory Squires introduces the topic and the two related articles. In his introduction, Prof. Squires provides the reader with background information about insurance redlining and highlights some of the findings and discussion in accompanying articles.

Next is an article by Professor George Galster called “Do Home Insurance Base Premium-Setting Policies Create Disparate Racial Impacts? The Case of Large Insurance Companies in Ohio.” Prof. Galster analyzes insurers’ pricing practices in Ohio based on data from the Ohio Civil Rights Commission on six large home insurers operating statewide. He investigates the degree to which minority homeowners face different base premium rates compared to white homeowners. Steve Dane, in an article titled “The Potential for Racial Discrimination by Homeowners Insurers Through the Use of Geographic Rating Territories” provides a detailed background to federal laws designed to prohibit racial discrimination. The article then discusses the Ohio study and highlights its limitations. Finally, the JIR includes a reprint of a chapter titled “Racial Profiling, Insurance Style” from Prof. Squires’ new book on race in America. Our hope is that these articles will help inform regulators and policymakers about the ongoing issues surrounding race and insurance.

Included in the remainder of this issue is an article by Professor John Robst titled “Changes in Medigap Supplemental Insurance Premiums, 1998–2000.” It examines the growth of premiums and looks at a prior study by Weiss Ratings, Inc., that reported growth in premiums for policies with prescription drugs at more than twice the rate for policies without such coverage. Prof. Robst re-examines Weiss’ findings and, based on a consideration of insurers’ market share, provides different results.

Finally, this issue of the JIR includes an article titled “Health Insurance Regulation by the States and the Federal Government: A Review of Current Regulation and Proposals for Change” by Mila Kofman (one of the JIR’s co-editors) and Karen Pollitz. This article provides an overview of how states regulate health insurance and the varying approaches for consumer protection and oversight. It also examines implications of three federal proposals that seek to federalize (to different degrees) the regulation of health insurance.

As always, we invite feedback from our readers.
Reigniting the Insurance Redlining Debate?

Gregory D. Squires*

Do the kids in the neighborhood play hockey or basketball?
— Anonymous Boston insurance agent (Luquetta 2002)

Insurance redlining is not the heated public policy issue it was just 10 short years ago. At that time, Congress was considering a disclosure rule that would have brought the kind of “sunshine” to the property insurance industry that the Home Mortgage Disclosure Act (HMDA) brought to mortgage lending. The nation’s largest insurers were in the process of settling fair housing complaints. And the U.S. Department of Housing and Urban Development (HUD) was considering a regulation clarifying the application of the Fair Housing Act to property insurance (Squires, 1998). The absence of such debate today reflects, in part, changes that occurred because of the advocacy of non-profit fair housing organizations. But evidence in the current case of National Fair Housing Alliance v. Prudential Ins. Co (208 F. Supp 2d (D.C.C., 2002)), the more recent debate over the use of credit scores (Birnbaum, 2003; Snyder, 2003; Tuckey, 2005; Texas Department of Insurance, 2004; Center for Economic Justice, 2005) in the pricing and underwriting of insurance, and informal discussions with staff at fair housing organizations (Smith, 2006) suggests that redlining may be making a “comeback.” It may be more subtle today than in earlier years, as suggested by the “hockey or basketball” question an insurer posed to one of its agents about a Boston neighborhood. But it persists. Two related articles in this issue of the JIR constitute a small but important step in what hopefully will be a broader public discussion of that re-emerging phenomenon.

Most prior research on insurance redlining and discrimination has examined the underwriting and marketing of policies. But pricing, which is more closely scrutinized by insurance regulators, is the focus of the following two articles by George Galster (“Do Home Insurance Base

* Professor of sociology, public policy and public administration, and chair of the Department of Sociology at George Washington University.
Premium-Setting Policies Create Disparate Racial Impacts? The Case of Large Insurance Companies in Ohio”) and Stephen M. Dane (“The Potential for Racial Discrimination by Homeowners Insurers through the Use of Geographic Rating Territories”). More specifically, they explore the implications of territorial rating for the prevalence of pricing practices that exert an adverse disparate impact on racial minorities.

Galster raises the question of what is the most appropriate geographic unit of analysis for determining whether territorial rating has a disparate impact. He considers several options and concludes that the least arbitrary and, therefore, most appropriate level is the state. He examines six large insurers in Ohio and concludes that, in general, the pricing practices of these companies do not yield higher premiums for minorities across the state as a whole. Dane demonstrates important limitations to state-level analysis, pointing out that such inquiries risk missing much of the “action” going on at the local level. He also notes that smaller units of analysis, like ZIP codes and census tracts, are too small to permit statistically reliable estimates of loss costs and, therefore, appropriate pricing. He concludes that municipal boundaries define the appropriate unit of analysis. Despite the rigor that both bring to the subject, it remains unclear at what geography disparate impact can be most effectively determined.

State-level analysis can be misleading, as Dane suggests, in part because of some of the empirical evidence Galster provides. He notes that non-metropolitan or rural areas tend to have higher premiums because of longer distances from professional fire departments, and whites disproportionately reside in these communities. So some whites are paying higher premiums for legitimate risk-related reasons. At the same time, racial minorities may be paying higher prices in the urban communities where they are concentrated, and those disparities could be due to discrimination. The end result would be the appearance of non-discriminatory pricing practices, with whites and non-whites paying comparable prices for insurance, but masking what could be systematic discrimination throughout the state’s several metropolitan areas.

This suggests the need for a more local examination of pricing practices. But relying on current municipal boundaries is also problematic. Just because the boundaries are determined by political authorities rather than insurers does not make race irrelevant in their designation or the consequences, including the price of insurance. For example, racially exclusionary zoning laws in most suburban communities contribute to the racial demography of the nation’s metropolitan areas. Though more diverse today than in the past, cities still tend to be disproportionately non-white and suburbs disproportionately white. If loss costs differ between cities and suburbs, this reflects a host of historical and ongoing inequities in both public and private investment and planning activities, including those of the home insurance industry (Badain, 1980; Yaspan, 1970; Massey and Denton, 1993; Dreier et al., 2004). If losses are higher in cities, such disparities reflect far more than the behavior and characteristics of current residents.
But using political jurisdictions, whose character has been shaped by conscious, as well as perhaps unintentional, racial bias as a basis for pricing insurance locks in and perpetuates into the future institutionalized discrimination, both historical and contemporary.

Another problem with using a city as a rating territory is that, contrary to what Dane asserts, it is often the case that there are sound actuarial reasons to believe one section of a city would lead to higher or lower losses than another section of that same city. Some neighborhoods are densely settled with high concentrations of wood frame homes, while others are sparsely settled primarily with brick homes. Fires are more likely to occur, and then spread to neighboring homes, in the former neighborhood. Theft rates also differ, sometimes dramatically, across neighborhoods. And it is increasingly the case that some inner-ring suburban neighborhoods experience the ills often previously associated almost exclusively with inner city neighborhoods (Orfield, 1997, 2002) and, therefore, have higher losses than many urban communities. Current municipal boundaries do not necessarily provide a reasonable basis for determining geographic rating territories.

Insurers often acknowledge that underwriting is as much an art as it is a science. Pricing, too, has its subjective dimensions. Determining appropriate boundaries for delineating geographic rating territories remains a challenge, as most insurers would likely acknowledge.

The overriding issue that remains is just how prevalent redlining and racial discrimination are in the pricing (as well as underwriting, marketing and other parts) of the home insurance industry. How much progress has been made, and to what extent redlining has made a “comeback,” cannot be systematically determined with data that are currently available, at least to the public. A critical next step is to secure an HMDA-like national disclosure law for home insurance. Some states have enacted limited disclosure laws. But they generally call for ZIP code, rather than tract-level, disclosure — and they often do not include denial rates or pricing information. Only a handful of states require any disclosure at all (Squires et al., 2001). The limited data available have proved useful in some of the fair housing litigation that has occurred (Lynch, 1997). But far more information is required in order to answer most of the questions that have been raised in several decades of debate over insurance redlining and discrimination.

Hopefully, these two articles will jumpstart a national discussion about the many unsettled issues. And, hopefully that discussion will generate the kind of systematic public information that will enable us to resolve remaining issues pertaining to insurance availability and unfair discrimination, and put this debate behind us.
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Do Home Insurance Base Premium-Setting Policies Create Disparate Racial Impacts? The Case of Large Insurance Companies in Ohio*

George Galster**

Abstract

The conventional wisdom is that the substantially higher home insurance premiums observed in urban compared to suburban rating territories have a disproportionate effect on minority homeowners because they are overrepresented in urban areas. Analyzing an unusual dataset acquired by the Ohio Civil Rights Commission from six large home insurers operating statewide, this study investigates the degree to which black, Hispanic and non-Hispanic white homeowners face different base premium rates, on average, based on where they reside in the state. The evidence shows that, from a statewide perspective, there is no consistent pattern of minority homeowners disproportionately living in areas with substantially higher base premiums, though results vary by company.

* The author wishes to thank Brandi Klein, Matt Miko and Ronnell Tomlinson of the Ohio Civil Rights Commission, who provided the premium data upon which this analysis was based. Thanks are also due the Office of Strategic Research, Ohio Department of Development, which assembled these data into geographic areas, and the Ohio Department of Insurance, which provided market share data. Greg Squires and anonymous referees provided constructive suggestions on an earlier draft. Noelia Caraballo provided production assistance. The opinions expressed in this note are the author’s, and do not necessarily reflect those of the Ohio Civil Rights Commission, the Ohio Department of Development or the Ohio Department of Insurance.

** Clarence Hilberry Professor of Urban Affairs, Wayne State University; george_galster @wayne.edu.
Based on their 2000 residential distribution across geographical rating territories, black and Hispanic homeowners are estimated to live in areas with 4% to 5% higher, on average, home insurance base rates charged by insurance companies C and D during 2002. The comparable figure is 2% to 3% in the case of insurance company E. In the case of company F, these differences are 1% or less. In the case of company B, black (Hispanic) homeowners live in areas with base rates up to 2% less (more), depending on policy type. In the case of company A, black and Hispanic homeowners live in areas with 3% to 5% lower base rates, on average. The findings raise the question of the appropriate geographic scale over which to assess potential disparate racial impacts of rating territory and premium designations: metropolitan area or state?

**Scholarly, Public Policy and Regulatory Context**

At least since the Kerner Commission Report (President’s National Advisory Panel, 1968), there have been widespread concerns that a variety of practices of home insurance companies have been racially discriminatory in their effect, and perhaps in their intent (e.g., Heimer, 1982; Kinkaid, 1994; Smith and Cloud, 1997; Squires, 1997, 2003; Yaspan, 1970). Subsequent decades of research has revealed insurance industry abuses in several areas: marketing and office location (Squires, Velez and Taeuber, 1991; Schultz, 1995, 1997), information provided (Galster et al., 2001), underwriting criteria (Powers, 1997), types of policies made available (Klein, 1997) and claims adjustment (Baker and McElrath, 1997; Saadi, 1987). There also have been several significant court findings returned against major insurance companies related to these behaviors (Lynch, 1997; Squires, 2003).

Another prominent area of concern relates to the oft-observed substantial differences in premiums charged in urban and suburban neighborhoods. In the most comprehensive study to date, Klein (1997) found for all policy types that predominantly minority-occupied ZIP codes evinced substantially higher average premiums (per $1,000 insured value) than predominantly white-occupied ZIP codes in a sample of 33 large metropolitan areas.

This observation raises a crucial question for scholars, policymakers and regulators alike: What is the source of this interracial/urban-suburban differential in premiums (as appropriately standardized)? Some have alleged that illegal, race-based overt and/or discriminatory differential treatment against individual minority homeowners and/or minority-occupied neighborhoods is to blame (ACORN, 1992; Tisdale et al., 1994; National Fair Housing Alliance, 1995). Studies employing the paired testing methodology to carefully control for all aspects of the insurance underwriting decision (except the racial-ethnic character of the individual
homeowner or the neighborhood where the home is located) have, however, produced mixed results in this regard (cf. Squires and Velez, 1987; Smith and Cloud, 1997; Galster, Wissoker and Zimmermann, 2001; Squires and Chadwick, 2006).

While acknowledging an interracial/urban-suburban differential in premiums in metropolitan areas, home insurance industry representatives have argued that these patterns are generated purely by rating territory structure, not differential treatment of individuals or neighborhoods. These rating territories and their corresponding differences in base premium rates, in turn, reflect risk differentials, as evinced by studies showing that insured losses due to crime, fire and other perils are higher in urban, minority-occupied neighborhoods (e.g., National Association of Independent Insurers, 1994). Moreover, they note that the insurance industry is heavily regulated by state insurance regulators, who require that differences in premiums across geographical areas (rating territories) be justified by actuarial loss histories (Wissoker et al., 1998: ch. 2).

Consumer and civil rights advocates have responded that, even if risks of loss vary substantially across space, the current design of metropolitan rating territories creates illegal disparate-impact discrimination against minorities. The argument is that current rating territory designations are arbitrary and force urban minority homeowners to bear higher premiums than are necessary. Some advocates have argued, for example, that minority homeowners’ premiums could, in principle, be lowered if the territories were redesigned to include combinations of suburban and urban neighborhoods. If these territories are well designed and premiums set appropriately, they claim, insurance companies could expect to earn the same rate of return under this hypothetical, nondiscriminatory scenario as under the status quo.

In this paper, I raise the question of whether the foregoing debate skirts a crucial point. Though the evidence on premiums clearly establishes a prima facie basis for alleging illegal disparate racial impact when the metropolitan area is used, it begs the question of whether such is the appropriate geographic scale of analysis. After all, insurance companies must have their statewide delineation of rating territories, premiums and policy types offered approved by each state’s appropriate insurance regulatory office. And there has never to my knowledge been a study of interracial differences in premiums conducted at the level of a state. This can undoubtedly be traced to the fact that states do not publicly report the appropriate data at a level of geography that could allow a formal test of disparate racial impacts of insurance pricing policies (Squires, O’Connor and Silver, 2001).

Fortunately, this barrier was removed recently in Ohio, where the Ohio Civil Rights Commission (OCRC) acquired data from the six large home insurers and granted access to the author for analyses at their behest. This research reports on the results generated by this unusual analytical opportunity.
The goal here is to ascertain the degree to which black, Hispanic and non-Hispanic white ("white" hereafter) homeowners face different premium base rates, on average, based on where they reside across the entire state of Ohio. The research is intended to answer the question:

To what extent did black, Hispanic and white homeowners in Ohio face different average home insurance premium base rates in 2002 because of the geographic rating territory in which they reside?

Put differently, the research will ascertain the degree to which the current structure of insurance rating territories and pricing thereof creates disproportionately higher base premiums for minority homeowners across Ohio as a whole.


Before turning to the evidence, important analytical foundations must be laid. First is the notion of disparate impact, which this paper investigates.¹ Illegal disparate impact occurs when a given policy or practice: 1) creates statistically disproportionate adverse effects upon a legally protected group; and either 2) there is no sound business justification for the policy or practice or 3) there is a sound business justification, but there is an alternative policy or practice that fulfills the same justification but has no disproportionate effects.²

In terms of the issue at hand, the policy or practice is the insurance company’s designation of its rating territories and its corresponding establishment of base premium rates for each (for a particular sort of policy type and dwelling type). A prima facie case of disparate impact would be established if the first condition above were met; i.e., if minority homeowners were distributed geographically such that their base premiums were higher, on average, than those faced by white homeowners. But the central issue is this: Over what set of rating territories should this comparison be made?

As means to an answer, consider the following thought experiment utilizing Figure 1. Figure 1 shows a stylized state (the rectangle) containing

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¹ I do not investigate here differential treatment discrimination, which would require analytically that otherwise risk-identical properties be charged different premiums based purely on the race of homeowner or the neighborhood. For examples of such a test, see Smith and Cloud (1997) and Galster, Wissoker and Zimmermann (2001).

² For more on standards of proof in disparate impact cases of discrimination, see Schwemm (1994) and Crowell, Johnson and Trost (1994).
one metropolitan area (the concentric circles) having two suburban municipalities (north and south) and one urban municipality (the inner circle). Also suppose that a hypothetical home insurance company has divided the state into five rating territories: suburban north, suburban south, urban east, urban west and rural. Finally, assume that only minority homeowners live in urban territories and only white homeowners live in suburban territories; let the composition of rural areas be a variable to be designated in the following discussion.

Figure 1

Hypothetical Illustration of Insurance Rating Territories in a State

Now consider some alternatives in our thought experiment. First, let us stipulate that the company’s base premium rates in minority-occupied urban west are significantly higher than those for comparable dwellings in white-occupied suburban south. Would this be sufficient grounds for assessing disproportionate adverse effect? I would argue not, based on the principle that the analytical choice of only these two territories is arbitrary, whereas the company’s delineation of territories across the state is holistic. This choice may also be misleading, insofar as minority-occupied urban east may have base premiums that are significantly less than those in white-occupied suburban north.

As a second alternative, stipulate further that the rural territory is white-occupied only and that its base premiums are higher than those in minority-occupied urban west. Would a comparison of (weighted) average premiums in the two white-occupied (suburban south and rural areas) and those in the urban west provide sufficient grounds for assessing disproportionate effect? I would argue not, because, again, only a subset of the company’s holistic
As a third alternative, do not specify the rural territory’s composition but stipulate that both minority-occupied urban territories’ average premiums are higher than those in either suburban territory. Would this be sufficient grounds for assessing disproportionate adverse effect? Again, I would argue not. The company’s “policy” in question is how they have parsed the state’s geography into rating territories in a holistic fashion and priced them correspondingly. To focus only on the metropolitan territories is to implicitly accept the area defined by its boundaries, but to do so also implies an acceptance of its converse: the rural territory defined by the same boundaries. The arbitrariness of considering only the “suburban side” of the suburban-rural boundary would become even more obvious if the company were to merge the rural and, e.g., suburban north territories.

I have argued that the least arbitrary choice of which territories to compare for a disproportionate-effect test is the entire set statewide. This will be operationalized in the following empirical work. I emphasize that such a choice does not bias the outcome. Adding rural rating territories will only sizably affect interracial comparisons based on metropolitan territories alone to the extent that: 1) rural base premiums are significantly different than either suburban or urban ones; and 2) significant shares of either the state’s white or minority homeowners reside in rural territories. I would also point out that the predominant racial composition of rural homeowners varies considerably among the states.

Sample and Data Sources

This research is based on information concerning six large home insurance companies operating statewide in Ohio. These companies were the objects of allegations by an Ohio private fair housing group that their policies regarding rating territory designation and pricing resulted in significantly higher premiums for minority than white homeowners in Cuyahoga County (Cleveland). All companies studied here ranked among the top 11 insurers on the basis of 2002 direct premium written in Ohio; collectively, they wrote 47% of such premiums. These companies issued insurance policies across all their rating territories statewide.

Analyses of these six home insurance companies were based on two sources of data. First, OCRC obtained from the companies their 2002 base premium rates and rating territory definitions filed with an independent state regulatory agency, the Ohio Department of Insurance. Base rate differentials among rating territories should reflect, according to state regulations, differences in actuarial histories of losses paid on policy claims (and/or expectations of such future claims) among the territories so defined.

3. The names of these companies must remain anonymous under terms of agreement with OCRC governing this research.
4. Unpublished data supplied by the Ohio Department of Insurance.
Base rates form the mathematical foundation upon which final premiums charged to policyholders are calculated. Though details vary across companies, the base rate typically is based on the home construction type (e.g., brick or frame) and the degree to which it is protected by a proximate, professional, full-time fire department (property protection class). Policies on frame homes located in rural areas with inferior public fire services usually have higher base rates. Further adjustments are made to this base rate in calculating the final premium, based on protection devices in the home, deductible amounts, owner’s credit score, multiple policies from the company held by the owner, etc. Regardless of the particulars of the home or its owner, however, all those who seek an identical amount of insurance on a similar construction type of home will face a common base rate from a particular company, based on the geographic rating territory in which the property is located. Thus, base rates, rather than actual final premiums, are the appropriate figure to compare in this study and in any analysis of the potential impacts of rating territory designations.

The base rates filed by the six insurance companies with the Ohio Department of Insurance in 2002 were used in this study. These base rates are calculated somewhat differently by each company. For example, Company C assigns a single base rate (for a given property type and coverage amount) in each of their 26 geographic territories, which generally consist of groups of contiguous counties or major metropolitan areas. Company D multiplies its single base rate by a different rating territory factor in each of its 71 territories; this is further scaled upward for higher amounts of insurance and frame dwellings. The base rates for Company B vary for each of its 35 territories, type of construction, amount of insurance and public protection classification. In this study, all the base rates are standardized to reflect $100,000 of insurance on a frame home.

The second source of data was the 2000 Census of Population and Housing, which provides information about the racial-ethnic composition of homeowners across Ohio. The Office of Strategic Research, Ohio Department of Development, assembled these data into geographic areas matching the individual rating territories of each of the companies analyzed. The key demographic data analyzed here were counts of the number of black, Hispanic and white homeowners in each of these rating areas.

5. It may be the case that minorities are more likely to reside in frame homes and, thus, pay a higher base premium. However, such data on type of home occupied by race are not available here. Moreover, the point is to compare premiums based on geographic pricing strategies, not particulars of dwellings.
6. Because public protection classifications vary within counties depending on local fire services, this posed an added challenge for collection of census data. Instead of tabulating homeowners by racial-ethnic category for an entire county or city, in this case they needed to be tabulated by each census place with a different public protection class within the given territory.
7. For this process, they employed Geographic Information Systems technology.
Analysis Strategy

To find out what an average homeowner of a given racial-ethnic group faces in terms of base rates in the rating territory in which they reside, one must take into consideration how that group’s homeowners are distributed across all the rating territories in Ohio. If one group is heavily concentrated in territories where base rates are highest, this should be reflected differently than if they were evenly spread across the state. This means that one must calculate a weighted average of base rates; i.e., an average wherein each territory’s base premium is weighted by the share of the given racial-ethnic group’s homeowners statewide that reside in this territory. The weighted average base rate premium, \( P(\text{weighted}) \), calculated for a particular racial-ethnic group, \( j \) (\( j = \text{black, Hispanic or white} \)), across \( n = 1, 2, \ldots \), across \( N \) different rating territories for a particular insurance company is expressed:

\[
P(\text{weighted}) = \frac{\sum_{n=1}^{N} P_n \cdot (HO_{jn})}{\sum_{n=1}^{N} HO_{jn}}
\]

where the symbol \( \sum \) means summation over all \( N \) territories in Ohio of the particular company in question, \( P_n \) is the base rate in territory \( n \), \( HO_{jn} \) is the number of homeowners of racial-ethnic group \( j \) residing in territory \( n \), and \( \sum HO_{jn} \) is the total number of homeowners of group \( j \) residing in Ohio.

It is important to emphasize that, unlike in many other statistical studies of racial differentials, further control variables are not needed here. Although territories presumably vary in a variety of demographic, economic and risk characteristics, these are irrelevant for the current research question. The issue is not differential treatment discrimination, or explaining or justifying base premium differentials, but rather ascertaining the degree to which territories and their associated base premiums have disproportionate racial effects.

\[\text{References}\]

8. The 2000 census reports homeowners in terms of units specified “owner-occupied.” In the counts reported here, whites are non-Hispanic, but Hispanics may be of any race. According to the 2000 census, in Ohio there were 2.8 million white, .21 million black and .03 million Hispanic homeowners.
Results

The computed weighted-average base rates are summarized for the six companies in Table 1. Note that for Companies B and C, two different types of policies having distinct base rates are shown. The table begins by listing the number of rating territories (zones) delineated by each company across the state. The weighted average base rates are then shown for white, black and Hispanic homeowners in Ohio. The weighted average shows what a homeowner in the given group faces as a base rate in the territory where the home is located, on average across Ohio. The B-W difference shows in dollar terms how much higher the weighted average base rate is for black than for white homeowners (a negative sign implying that the figure for whites is higher). The column marked “B/W” shows the ratio of black-to-white average base rates. Thus, a figure of .979 indicates that the average base rate for black homeowners is 97.9% of (or 100 - 97.9 = 2.1% lower than) the rate for white homeowners; a figure of 1.048 indicates that the average base rate for black homeowners is 104.8% of (or 4.8% higher than) the rate for white homeowners. Analogous figures are reported for differences between white and Hispanic homeowners’ base rates.

Table 1

Weighted Average Homeowners Insurance Base Rates In Ohio, 2002
by Racial-Ethnic Group And Insurance Company
(Calculated for $100,000 coverage on frame home)

<table>
<thead>
<tr>
<th>Company</th>
<th>N of Rating Zones</th>
<th>W White**</th>
<th>B Black</th>
<th>B-W Difference</th>
<th>B/W</th>
<th>H Hispanic</th>
<th>H-W Difference</th>
<th>H/W</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-BP</td>
<td>34</td>
<td>408.47</td>
<td>396.74</td>
<td>-11.73</td>
<td>0.971</td>
<td>387.63</td>
<td>-20.84</td>
<td>0.949</td>
</tr>
<tr>
<td>B-EC</td>
<td>35</td>
<td>204.18</td>
<td>199.97</td>
<td>-4.21</td>
<td>0.979</td>
<td>204.74</td>
<td>0.56</td>
<td>1.003</td>
</tr>
<tr>
<td>B-MV</td>
<td>35</td>
<td>255.79</td>
<td>254.40</td>
<td>-1.39</td>
<td>0.995</td>
<td>259.79</td>
<td>4.00</td>
<td>1.016</td>
</tr>
<tr>
<td>C-SF</td>
<td>26</td>
<td>1293.37</td>
<td>1355.37</td>
<td>62.00</td>
<td>1.048</td>
<td>1350.93</td>
<td>57.56</td>
<td>1.045</td>
</tr>
<tr>
<td>C-PP</td>
<td>26</td>
<td>1470.27</td>
<td>1540.75</td>
<td>70.48</td>
<td>1.048</td>
<td>1535.37</td>
<td>65.10</td>
<td>1.044</td>
</tr>
<tr>
<td>D-EEI</td>
<td>71</td>
<td>380.29</td>
<td>397.69</td>
<td>17.4</td>
<td>1.046</td>
<td>401.24</td>
<td>20.95</td>
<td>1.055</td>
</tr>
<tr>
<td>E-OO</td>
<td>34</td>
<td>452.93</td>
<td>465.34</td>
<td>12.41</td>
<td>1.027</td>
<td>463.53</td>
<td>10.60</td>
<td>1.023</td>
</tr>
<tr>
<td>F-BP</td>
<td>24</td>
<td>451.57</td>
<td>455.96</td>
<td>4.39</td>
<td>1.010</td>
<td>451.11</td>
<td>-0.46</td>
<td>0.999</td>
</tr>
</tbody>
</table>

** White = Non-Hispanic white
* BP=Basic Premium; SF=Special Form; PP=Protector Plus; OO=Ohio Options; EEI=Elite II; EC=Extra Cover; MV=Market Value Policy for frame home $100,000 coverage

Source: Author’s calculations of insurance company data reported to Ohio Department of Insurance.

9. The base rates for Company C appear extraordinarily high, but this is an artifact because it applies a series of customer- and home-specific discounts that ultimately bring the final premium to a level competitive with the other companies’ base rates.
As can be seen in Table 1’s comparisons of differences in weighted average base rates of black and white homeowners, the greatest difference is for Company C, where the two policy types investigated show that blacks’ averages are $62 and $70.48 (both 4.8%) more. Companies D and E are next, with $17.40 (4.6%) and $12.41 (2.7%) higher averages for blacks, respectively. Company F evinces a $4.39 (1.0%) higher average for blacks. By contrast, Company A and both of Company B policies investigated show that averages for blacks are lower than for whites, by up to $11.73 (2.9%).

As can be seen in Table 1’s comparisons of differences in weighted average base rates of Hispanic and white homeowners, the greatest absolute differences again is for Company C, where the two policy types investigated show that Hispanics’ averages are $57.56 and $65.10 (4.4% to 4.5%) more. Companies D and E again are next, with $20.95 (5.5%) and $10.60 (2.3%) higher averages for Hispanics, respectively. The two Company B policies investigated show that averages for Hispanics are $4 (1.6%) and $.56 (0.3%) higher. By contrast, Companies A and F show that averages for Hispanics are lower than for whites, by $20.84 (5.1%) and $.46 (0.1%), respectively.

Discussion

The evidence here shows that black, Hispanic and white homeowners in Ohio do not, in general, face substantially different average home insurance base premium rates when all companies are considered collectively. The precise extent of any differential in 2002 depends on the particular insurance company considered. However, in no cases are the minority-white differences more than 5%, and in two cases this differential favors black homeowners. Based on their 2000 residential distribution across geographical insurance rating territories in Ohio, black and Hispanic homeowners are estimated to live in areas with 4% to 5% higher, on average, home insurance base rates charged by Companies C and D during 2002. The comparable figure is 2% to 3% in the case of Company E. In the case of Company F, these differences are 1% or less. In the case of Company B, black (Hispanic) homeowners live in areas with base rates up to 2% less (more), depending on policy type. In the case of company A, black and Hispanic homeowners live in areas with 3% to 5% lower base rates, on average.

These findings are remarkable, given that they at first glance seem to fly in the face of conventional wisdom regarding the putatively large disparate racial impacts of metropolitan insurance premium pricing. These findings and the conventional wisdom can be reconciled, however. When we consider only urban and suburban rating territories within Ohio metropolitan areas, base rates in the former are always substantially higher, producing an average base rate for minority (primarily urban) homeowners that is considerably higher than for white (primarily suburban)
homeowners, and on par with those observed by Klein (1997). What clearly makes these disparities nearly disappear statewide is the inclusion of non-metropolitan (rural and smaller town) rating territories in the weighted averages. In Ohio, these territories have high base rates (primarily because of long distances from professional fire departments) and large numbers of mainly white homeowners, thereby substantially raising the weighted average premiums for whites statewide.

Of course, the finding of, at most, modest racial-ethnic disparities in the geographic premium-setting policies of the largest insurance companies in Ohio may not necessarily be generalized to other states. Certainly, in other regions of the country (such as the South), the rural homeowner populations will be more heavily minority than in Ohio. Moreover, Ohio has one of the lowest average homeowners insurance premiums in the nation.\textsuperscript{10} Thus, statewide comparisons in other states may reveal substantial disproportionate racial effects. Finally, I have not analyzed the extent to which geographic differences in premiums observed here may be based on a sound business rationale, such as actuarial evidence of differences in losses paid on claims. Thus, I make no claims about the fairness and efficacy of alternative rating territory designs.

Several additional caveats should conclude the discussion. First, even though base premium rates are the most appropriate indicator for an investigation of potential disparate impacts of rating territory designation, the actual premium paid by homeowners (after all characteristics of the homeowner and dwelling are taken into account) is also of interest. Indeed, many other important insurance outcomes (alluded to in the introduction) are important to consider in a holistic analysis of the insurance industry and race. Second, I noted the intercompany variability of interracial differentials in base premium rates in Ohio. The 4% to 5% differential evinced by Company C, for example, may be sufficiently worrisome to suggest further investigation.

Conclusions and Policy Implications

The current structure of rating territories and premium pricing thereof by six major home insurance companies in Ohio does not appear in general to create disproportionately higher premiums for minority homeowners across the state as a whole, though at least one companies’ practices may be questioned on these grounds. This finding raises a fundamental and challenging question for civil rights and community advocates, insurance

\textsuperscript{10} In 2002, Ohio ranked 47th in average premium (Insurance Information Institute, 2005).
companies and their state regulators, and legal scholars alike:

What is the “correct” geographic scale over which premiums (or any other insurance parameter) should be compared in ascertaining whether there is an illegal disparate impact on minority homeowners: metropolitan area or state?

It has been traditional in analyses of property insurance to consider a single metropolitan area as the “market,” because it is the territory over which most households search for housing. But why is this necessarily the appropriate area for assessing disparate impact? In this paper, I have argued that a more appropriate assessment involves all territories statewide. Here, if the entire state of Ohio is included, the prima facie requirement of possibly illegal premium pricing policies — i.e., of creating a disproportionate statistical effect — arguably is not met in general. This renders moot any subsequent proof regarding the lack of justifiable business necessity of such pricing policies. Indeed, this was the position that the OCRC took in this particular instance, and no further actions were taken against the insurance companies.

Clearly, much more legal and social scientific analysis is required on this issue. In particular, statewide analyses comparable to this one should be conducted in other states besides Ohio. Moreover, the study of the fairness of premium-setting policies could be advanced by consideration of the geographic variation in the ratio of policy premiums collected to losses paid to claimants (see, e.g., Galster et al., 2004).
References


The Potential for Racial Discrimination by Homeowners Insurers Through the Use of Geographic Rating Territories

Stephen M. Dane*

Introduction

Over the past two decades, the homeowners insurance industry has been battered by claims of race discrimination in the underwriting, marketing, advertising and sale of its products. Nearly all of the major carriers, and several smaller ones, have been the subject of civil rights enforcement actions. Led primarily by private fair housing and civil rights groups,1 discrimination claims have been filed in federal courts under federal fair housing laws, in state courts under state civil rights laws and before federal and state administrative agencies charged with enforcing both.

The results have been dramatic. Most homeowners insurers no longer use dwelling age or minimum market value as part of their underwriting processes, two criteria that substantially limit the availability of

* The author is a fair housing attorney with Relman & Associates, PLLC, Washington, D.C. He has been one of the lead lawyers for the plaintiffs in many of the insurance discrimination and insurance redlining cases brought against homeowners insurers, including those cited in this article.

1. Almost all of these administrative and court claims have been filed by non-profit fair housing and civil rights organizations. The U.S. Department of Justice has filed only two claims against homeowners insurers, in each case as a result of investigations begun by a civil rights group. The Ohio Civil Rights Commission has also found probable cause in response to complaints filed by private fair housing organizations. With some limited exceptions, state insurance regulators have not been active in this area.
homeowners insurance in African-American, interracial and minority neighborhoods. Restrictions on the availability of full and guaranteed replacement cost policies have also been eliminated, with companies finally making such policies available in African-American and minority neighborhoods. Insurers have abandoned explicitly race-based and geographically based marketing plans.

These challenges to traditional underwriting and marketing practices have been supported both by testing of agents conducted by fair housing organizations and by statistical analyses demonstrating the racial impact of certain facially neutral criteria. Many of the challenged underwriting criteria were not supported by any company or industry empirical loss or claims data, so they could not be justified by business necessity.

Insurer pricing mechanisms have not garnered as much civil rights attention. This is because, in contrast to traditional underwriting and sales behavior, insurance ratemaking historically has been premised on the sophisticated actuarial analysis of loss and claims data. Moreover, with the few exceptions noted in this article, most of the factors traditionally used by insurers to generate an insurance premium are not known to have racial implications, unlike underwriting criteria such as the age and market value of dwellings.

One area where traditional insurance pricing procedures might have racial consequences is the use of geography. Neighborhood racial composition has historically been used by homeowners insurers to distinguish between underwriting risks and, over time, insurers have increasingly used rating territory delineations to distinguish between risks for pricing purposes. Yet many large metropolitan areas in the United States remain highly segregated, and there is the potential that charging different rates in different sections of the same city might result in racially identifiable neighborhoods being charged different rates.

This paper discusses the potential racial implications of using geographic rating territories in the homeowners insurance rating process.


3. Factors traditionally used to determine the base rate of homeowners policies are type of construction, type of policy, amount of insurance, protection class, amount of deductible and rating territory. Of these factors, none other than the one based on geography — rating territory — are suspected to have racial implications. Recently, some insurers have begun using credit scores or insurance scores or other economic data to calculate base rates. These components likely have a disparate racial impact on protected groups. A discussion of the disparate racial impact of credit data is beyond the scope of this article.

Specifically, the paper addresses a homeowners insurer’s potential exposure to legal liability under the federal Fair Housing Act by the use of geographic rating territories to determine rates. The article first provides an overview of the Fair Housing Act and its impact on insurance practices. It identifies those practices relating to the use of geographic rating territories that are most likely to lead to legal liability under the Fair Housing Act. The paper next discusses one recent study, “Do Home Insurance Base Premium-Setting Policies Create Disparate Racial Impacts? The Case of Large Insurance Companies in Ohio” of statewide homeowners premium data in Ohio and the implications of rate-setting practices for minority residents. This article highlights some limitations to the study as a tool to determine whether insurers’ practices are the result of prohibited discrimination.

**Fair Housing: Background**

*Fair Housing Basics*

The Fair Housing Act prohibits discrimination in “residential real estate-related transactions.” That term includes, among other transactions, the providing of financial assistance for constructing or repairing a dwelling, which is what homeowners insurance provides. Every court to address the issue since the Fair Housing Act was amended in 1988, as well as the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Justice, has concluded that the Act prohibits racial and other types of discrimination by homeowners insurers.

Thus, any form of intentional racial discrimination is prohibited by the Act. This would include, for example, refusing to make certain types of policies available to minorities or avoiding doing business in predominantly minority neighborhoods. Developing marketing plans that expressly take into account the racial makeup of a neighborhood—a surprisingly prevalent practice even today—would also violate the Act as a form of intentional discrimination.

Another important concept under the Act is the notion of “disparate impact.” Under this legal theory of liability, an insurer violates the Act if a

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6. See, generally, Dane, S., 1997. “Application of the Fair Housing Act to Homeowners Insurance,” in G. Squires (ed.), *Insurance Redlining: Disinvestment, Reinvestment, and the Evolving Role of Financial Institutions* (Urban Institute Press). The McCarran-Ferguson Act does not compel a different result. Id. McCarran-Ferguson, which sometimes prohibits the application of federal laws to the “business” of insurance, is triggered only if the federal law conflicts with state law governing the same behavior. Because almost all state laws also prohibit unfair discrimination on the same bases as the federal Fair Housing Act, the courts have uniformly rejected McCarran-Ferguson challenges to fair housing claims against homeowners insurers.
business practice, racially neutral on its face, nevertheless has a disparate impact on minority homeowners or on homeowners living in predominantly minority neighborhoods. If a policy or practice is shown to have such an effect, even if not intended to do so, the policy or practice is illegal, unless the insurer can show that there is a compelling business justification for the policy or practice, and that no less discriminatory alternative exists to achieve the same business purpose. Many traditional underwriting practices, like the housing age and value criteria mentioned earlier, have been successfully challenged under the Act using a disparate impact analysis.7

The Fair Housing Implications of Geographic Rating Territories

Insurance ratemaking is essentially an attempt to predict the future. Except for the delineation of rating territory boundaries discussed below, it is a mathematical means of deriving an appropriate rate that will be sufficient to pay losses expected to occur in the future, while also generating enough funds to pay administrative expenses and allow for a reasonable profit. Despite its technical complexity and actuarial foundation, the ratemaking process is admittedly imperfect and contains more than enough opportunity for subjective judgments and manipulation.8 For purposes of this discussion, however, we are concerned only with the question of whether homeowners insurers’ use of geographic rating territories might constitute violations of fair housing law or have racially discriminatory consequences or impacts.9


8. The ratemaking process frequently allows and even requires subjective judgments to be made in several categories, including the selection of appropriate data sources, data integrity, data organization, data credibility, homogeneity of risk groups, appropriate weighting factors, legal and regulatory influences, and even marketing considerations. See, generally, Statement of Principles Regarding Property and Casualty Insurance Ratemaking (May 1988) published by the Casualty Actuary Society (reprinted at www.casact.org/standards/princip/sppcrate.pdf). This is why property and casualty insurers claim a proprietary interest in their individual ratemaking processes; they do not want competitors to learn their “secret sauce” and, therefore, obtain a competitive advantage.

9. So, for example, this article does not discuss the very real legal and public policy problems presented by the homeowners insurance industry’s recent adoption of credit or insurance scores to underwrite or to price individual insurance policies. No one — not even Fair Isaac Corporation, which pioneered the use of credit data in the homeowners insurance industry — disputes that the use of credit data results in higher rejection rates for minorities than for whites. Statement of Peter L. McCorkell, Profitwise (Fall 2000) at p. 15 (Federal Reserve Board), available at www.chicagofed.org/publications/profitwise/2000/pwaug00.pdf. A discussion of that issue is beyond the scope of this article.
The concept of geographic rating territories is not, per se, objectionable on a fair housing basis. The use of reasonable geographic boundaries to charge different prices based on different loss costs is acceptable, so long as the selection of the boundary lines is risk-based and does not discriminate on the basis of race.

For example, in most markets the use of political boundaries (e.g., county limits, city limits, etc.) to define rating territory boundaries generally does not raise fair housing implications, or at least does not suggest intentional race-based discrimination. Levels of fire protection, police protection, rebuilding costs and the existence of environmental hazards may all differ from one political subdivision to the next, even among those that are in close geographic proximity. A large city with a sophisticated fire department may indeed deserve different rating treatment than a nearby township with a largely volunteer fire workforce. The standard rating territory definitions established by the statistical agent ISO and used by many smaller insurers are set up this way, and they have not been challenged on fair housing grounds.

Moreover, loss costs are often higher in major metropolitan cities than in their surrounding counties. Not only are loss costs usually higher in the cities, but claims frequencies may also be higher in cities than in the surrounding suburban and rural areas. Combine higher average loss costs with higher claims frequency rates and the result is inevitable: Cities may very well require higher base insurance rates than the surrounding adjacent communities.

So any claim that differences in homeowners insurance prices between “suburban” and “urban” areas are inherently racially discriminatory misses the mark. For example, the Ohio Civil Rights Commission found as much when it thoroughly investigated such a misguided claim and found no evidence to support it. Moreover, such “urban” versus “suburban” claims paint with too broad a brush. Most major metropolitan areas are still majority white, just like their surrounding suburban communities. Conversely, many major metropolitan areas have suburban communities that are themselves predominantly minority.

Of more interest to fair housing organizations and civil rights enforcers is whether a particular homeowners insurer has carved up a single municipality into sub-city rating territories that have significantly different racial demographics. Insurers typically do not have enough loss data to justify rating territories smaller than citywide. Because on a citywide basis, fire protection, crime prevention and rebuilding costs are all the same, there

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is no actuarial reason to believe one geographic section of a city would lead to higher or lower losses than another section of the same city.

But if a company uses ZIP codes, and not political boundaries, to delineate its rating territory boundaries, then the relevant inquiry becomes how the company exercised its judgment to group different ZIP codes together into one rating territory. ZIP codes are not necessarily co-extensive with political boundaries. A single ZIP code can cross two or more political boundaries, with different levels of fire protection, different police departments, different zoning codes, different environmental hazards, etc. Grouping several ZIP codes together compounds such dissimilarities. Because loss data at the ZIP code level is generally not credible enough to draw strong conclusions about predicted losses, the company must use some additional criteria to choose the territorial boundaries. The additional criteria may or may not have racial implications.

Let’s take examples from two extreme ends of the spectrum. Assume an insurer chooses to have only one rating territory for an entire state. That is, all policyholders in the state pay the same base rate. There can be no racially disparate impact. In this circumstance, it does not matter at what geographic level one chooses to analyze the data. All policyholders in black neighborhoods are charged the exact same base rate as all policyholders in white neighborhoods.

Although having only one rating territory for an entire state immunizes an insurer from any geographic racial redlining claim, doing so makes no sense from an insurance standpoint. This is because geography matters. Insurance losses do differ based on location and geography.

Now let’s take the other extreme. Assume an insurer chooses to delineate rating territories throughout the state at an extremely fine geographic level, such as ZIP code or, maybe, census tract or block group. At this level, clear racial differences will appear in the demographics of the territories. The vast majority of ZIP codes, census tracts and block groups are heavily predominated by only one racial group. This is simply a reflection of the fact that America’s neighborhoods are still heavily segregated.

Pricing differentials at this extremely small geographic level will, therefore, have potentially significant racial consequences. If two different rating territories that have been created based on ZIP code or census tract are associated with different base rates, the chance that two different racial groups will be charged different base rates increases dramatically.

But at this small geographic level, there is not enough loss data, standing alone, to justify the calculation of an actuarially sound base rate. Loss data at the ZIP code or census tract level is not credible enough to be the sole basis for generating a base rate. In contrast to the statewide rating

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11. Although all homeowners insurers collect and maintain data at the ZIP code level, it is rare to see data collected at a finer geographic level, such as census levels. Nevertheless, current technological capabilities make it is easy to do so, and it is not beyond the realm of possibility that insurers would choose do so in the future.
territory model, which may be mathematically sound but not very useful in distinguishing between geographic risks, the finely tuned ZIP code rating territory model distinguishes geographic areas at a very detailed level, but is not mathematically sound.

So how does an insurer who has chosen to carve up its rating territories into units smaller than the boundaries of the political unit in which the territories are located determine where to draw the territory boundary lines? How does it decide which ZIP codes, census tracts, neighborhoods or streets to include in which municipal rating territory?

It is at this point in the ratemaking process — the territory boundary line delineation decision — that racial influences and effects can appear, and they can be dramatic. Many times, insurers will allow marketing considerations or agent preferences to influence this decision; such factors might implicate racial preferences, either intentionally or subconsciously. Certain ZIP codes might be subjectively perceived as “more preferable” from a marketing perspective and, therefore, be “placed” in a better-rated territory. Conversely, other areas might be considered “less desirable” to the insurer or its agency force, or might not fall within the company’s “target market” and, therefore, be deliberately placed in a higher-rated territory.

Sometimes territory boundaries are chosen based on factors that are facially neutral, but that have been proven in some markets to have racially disparate consequences, such as dwelling age or market value. For example, an insurer might decide to include ZIP codes falling along the potential boundary between two rating territories in the higher-rated territory simply because their median housing values are lower than median housing values in the higher-rated territory. In a metropolitan area where minorities are more likely to live in such ZIP codes, they will have been placed in a higher-rated territory (thus paying higher base prices) based on a factor (median housing value) that has no bearing on their actual loss costs. The result: The racial demographic differences between the two rating territories become more pronounced, and more homeowners in minority neighborhoods pay higher base rates in that political jurisdiction without any corresponding direct loss-cost justification.

Territory boundaries smaller than the political subdivision in which they sit might also be chosen based on seemingly neutral criteria like waterways or railroad tracks or expressways, especially if such features also correspond to ZIP code boundaries. This, too, can have racial consequences. Racially segregated neighborhoods tend to demarcate along such features, and using them as rating territory boundary markers merely perpetuates the racial consequences of pre-existing housing patterns. Yet without sufficient loss data at such fine geographic levels to adequately predict loss costs, the result could be unjustifiably higher insurance rates for minorities within that geographic area.

Insurers typically have addressed the rating territory data credibility problem by aggregating loss data from different rating territories into larger groups for purposes of deriving an appropriate rate. These larger analytical
groups may have no geographic connection to each other; i.e., rating territories from diverse parts of the state might be “grouped” together for this purpose. This may be acceptable from a fair housing standpoint if the criteria for aggregation are not themselves race-based or have no racial implications. But if the bases for aggregating different rating territories into larger groups for purposes of rate derivation themselves could have racial effect connotations (e.g., by considering dwelling age or median value), then the racial consequences of the aggregation will simply pass through to the final rate derivation results.

So if a homeowners insurer has chosen to subdivide a municipality into smaller rating territories that have significantly different racial demographics, and if the base prices charged in those sub-city rating territories are different, then a civil rights inquiry is warranted to see why the insurer chose the rating territory boundaries that it did, and to determine why two different territories with the same general political and economic characteristics could result in two different base pricing structures.

Discussion: Do Home Insurance Base Premium-Setting Policies Create Disparate Racial Impacts? The Case of Large Insurance Companies in Ohio

This companion article analyzes a dataset from six large home insurers in the state of Ohio and concludes that “from a statewide perspective” there is “no consistent pattern” that minority homeowners pay disproportionately higher premiums, “though results vary by company.” The author suggests that the study, therefore, raises the question of the correct geographic scale over which premiums should be compared in ascertaining whether there is an illegal disparate impact in homeowners insurance pricing. There are several flaws in the study’s approach, however, that limit the implications of its findings for determining discriminatory behavior.

Policy research like that of the companion study may be useful in determining whether there is, and the scope and extent of, systemic problems of discrimination throughout a segment of the housing market, such as homeowners insurance pricing. But determining the extent of discrimination in the market as a whole does not answer the question of whether a specific participant in that market is engaging in discrimination, either by design or in effect. Overall market results may mask the discriminatory policies of a specific market participant.

12. In this paper, the term “economic characteristics” means only those economic indicators that affect an insurer’s loss and liability costs, such as the price of labor and materials needed for repairing, rebuilding or replacing structures. The term does not include economic characteristics of the people living in a neighborhood, such as wealth or income.
This possibility is suggested in the study itself. Although the author concludes that minority and white homeowners in Ohio do not in general pay substantially different average base premium rates when all six companies are considered collectively, the data do show that two-thirds of the companies under study (four out of six) charge black homeowners higher base prices. Setting aside the question of whether the difference in price charged by those four insurers is legally significant, the point here is that the non-discriminatory pricing behavior of only two companies could mask the potentially discriminatory pricing behavior of the other four in the study. The conclusion that there is no discrimination dysfunction in this subset of the market, therefore, is unsupported. In other words, one cannot conclude, for example, that a statewide housing market in which two-thirds of the participants discriminate against minorities is functioning appropriately “from a statewide perspective” because the remaining one-third of the market treats blacks fairly.

The more significant problem, however, is the assumption that an insurance company’s “delineation of territories across the state is holistic,” and that, therefore, any disparate impact analysis must look at the statewide market, not individual metropolitan markets within the state. First, it is unclear what this means, and it is inconsistent with actual market behavior. Many homeowners insurers do, in fact, delineate their territory boundaries within metropolitan areas in ways unique to each metropolitan market. As discussed earlier in this paper, they may do so in a variety of ways, some of which do not raise particular civil rights or disparate impact concerns (e.g., the use of political boundaries), and some of which do raise such concerns (e.g., ZIP code or census tract).

Second, it is debatable whether fair housing claims based on geographic or neighborhood-based discrimination can even be filed on a geographic basis as extensive as statewide. The U.S. Supreme Court has upheld claims based on alleged neighborhood discrimination when they have challenged the effects of discrimination within “relatively compact neighborhoods,” such as apartment buildings, metropolitan areas or cities, and perhaps even entire cities or surrounding counties, but has indicated

13. There is no bright-line standard for determining what constitutes a significant enough disparate “impact” to trigger liability under a disparate impact theory. See, e.g., Abbott v. Federal Forge, Inc., 912 F.2d 867, 873 (6th Cir. 1990) (recognizing there are many ways to assess the significance or sufficiency of evidence and acknowledging that no rigid mathematical formula applies). In any event, any difference in price between protected classes is a violation of law if the difference is intentional.

14. It bears observing that the two companies who were found to charge lower average base prices to black homeowners did so in the range of -1.39 to -11.73 dollars. In contrast, the four companies who were found to charge black homeowners higher prices did so in amounts as high as +62.00 and +70.48 dollars. Regardless of the appropriateness of looking at the base price differences in relative (percentage) terms as opposed to real dollar terms for purposes of imposing legal liability, the notion that tens of thousands of black homeowners throughout the state would have to pay $70 more per year for their base homeowner insurance — without any corresponding evidence of increased risk — should be considered unacceptable from a public policy perspective.
that is about as far as it will go.\textsuperscript{15} In one of the few certified class actions against a homeowners insurer for alleged discrimination, an Ohio court certified a class of homeowners in predominantly black census tracts, but only within the political boundaries of the city of Toledo.\textsuperscript{16} A claim that a black homeowner in Cleveland would be adversely affected by a homeowners insurer’s pricing practices in the city of Cincinnati would be fundamentally flawed. Therefore, using statewide analysis — as the study attempts to do — presents a problem when trying to assess whether insurers are engaged in illegal behavior.

So, any analysis of statewide pricing data from a group of insurers may be of some interest to economists or policymakers, but cannot be used to prove that any individual insurer has or has not violated state or federal civil rights laws in its pricing behavior. Moreover, because insurers have themselves chosen to charge different prices based on discrete geographic segments (rating territories) contained in diverse geographic markets throughout the state, it is appropriate to analyze insurer data and behavior in those markets alone, without reference to its behavior in different geographic markets or throughout the state as a whole.

There are other problems with the approach adopted in the study. For example, the study attempts to measure the presence of base price differentials among minority homeowners throughout the state instead of base price differentials among minority neighborhoods with high minority resident concentrations. It does so by weighting each rating territory’s base rate “by the share of the given racial-ethnic group’s homeowners statewide that resides in this territory.”

But the fundamental premise of a geographic racial redlining claim is that the overall racial population of the neighborhood, not the percentage of minority homeowners in the neighborhood, is a motivating factor driving the defendant’s behavior. By placing weights based on the race of homeowners within each territory, the study overlooks entirely the effect of overall neighborhood racial composition. By focusing on race of insured instead of racial composition of the territory, the study weights the wrong factor.

Moreover, when an insurer charges higher base rates throughout an entire rating territory because of its overall racial composition, \textit{all persons} buying insurance within that neighborhood — minority and white — pay higher base rates and suffer the effects of the discrimination. But in weighting the analysis by percentage concentration of race of homeowner, the companion study effectively “reduces” the impact of the pricing differential in predominantly minority territories by the percentage of white homeowners also residing in the territory, even though the white


\textsuperscript{16} \textit{Toledo Fair Housing Center v. Nationwide Mutual Ins. Co.}, 94 Ohio Misc. 2d 17, 22, 703 N.E.2d 340 (Common Pleas Ohio, 1996).
homeowners pay the same higher rate as their minority neighbors. Once again, the analytical methodology does not accurately measure the true potential price disparities that could exist between predominantly minority rating territories and white territories.

Conclusion

Generally speaking, the non-geographic factors that drive homeowners insurance base rates — such as policy type, type of construction, amount of insurance, amount of deductible and protection class — do not trigger serious fair housing concerns. Such factors have no known racial connotations. The primary fair housing question raised by homeowners insurer pricing practices is the extent of, and reasons for, rating territory boundary delineations in metropolitan markets with racially segregated housing patterns. If an insurer uses existing political boundaries to define its rating boundaries, fair housing concerns are not usually implicated. Such boundaries have been defined by governmental authorities, not the insurers themselves, and make intuitive sense for insurance purposes in light of differences in police and fire protection, zoning requirements and enforcement, and other potential risk factors. But if an insurer does not use pre-existing political boundaries within a single metropolitan area, and instead creates artificial territory boundaries by the use of non-risk related geographic determinants like ZIP code or census tract, then fair housing concerns might be implicated. If the resulting rating territories contain significantly different racial populations and different base rates, a further inquiry is certainly warranted.

In any event, analysis of industrywide base rate data throughout an entire state is not helpful when trying to determine whether an individual insurer is violating state or federal civil rights laws in its pricing practices. Even a study of an individual insurer’s application of base rates throughout an entire state and across all policy types and policy forms provides little insight, for an insurer’s legitimate and lawful behavior in one or more metropolitan markets may completely mask its racially discriminatory pricing conduct in another. As is typical for civil rights claims generally, any allegations of discrimination on the basis of race against an insurer should be focused and narrowly tailored to the particular market at issue.
Racial Profiling, Insurance Style*

Gregory D. Squires
Charis E. Kurbrin

“Very honestly, I think you write too many blacks...you got to sell good, solid premium paying white people ... the white works.”

It is unclear whether the mortgage lending or property insurance industry “pioneered” the use of neighborhood, and particularly the racial composition of neighborhood, in evaluating applicants for housing related financial services. But such redlining practices have a long history. And if racial profiling is most closely associated with the behavior of certain police officers and other security officials, it has a “rich” tradition in insurance.

Racial profiling has emerged as a leading civil rights issue in social science research and policy circles today. Profiling refers to practices through which individuals are classified, at least in part, on the basis of their race or the racial composition of their neighborhoods and treated differently as a result. Although the debate over racial profiling most frequently focuses on policing and administration of justice issues, a topic explored in Chapter 6, such practices are not restricted to this arena. In fact, at least financially and economically, far more damage is done by racial profiling in other areas of public and private life. One of those is the property insurance industry. The costs include not just diminished opportunities for racial minorities, but the exacerbation of uneven development of metropolitan areas, and the many costs associated with that pattern. This chapter examines the historical and ongoing practices of racial profiling and related discriminatory actions on the part of the property insurance industry in the United States — actions that helped to create and reinforce the linkages among place, race, and privilege. These practices are hardly unique to any particular industry. In fact, they reflect longstanding racial stereotypes that

have stigmatized racial minorities throughout much of American society, and continue to do so at great expense to minority communities and metropolitan areas generally. Remedies are available and directions for future policy initiatives are explored.

**Insurance, Home Ownership, and Urban Development**

The property insurance industry has a long and continuing tradition of racial profiling. If such practices were once considered sound professional business practices and explicitly endorsed by the industry, few publicly defend them today. Yet they persist. While redlining and racial discrimination by mortgage lenders and banking institutions generally have long been subject to research and public policy initiatives (Goering and Wienk, 1996; Haag, 2000; Munnell et al., 1996; Ross and Yinger, 2002; Stuart, 2003), equally pernicious, but less scrutinized, has been the behavior of the property insurance industry (Badain, 1980; Galster et al., 2001; Squires, 1997). Yet insurance is critical, or, in the industry’s term, “essential.” If a potential homebuyer cannot obtain a property insurance policy, no lender can provide a mortgage. The risk of financial loss to the mortgage lender would simply be too great if the property is not insured. Should the home be damaged, the lender needs to know that its investment is secured and that the loan will be repaid. Property insurance on the home, along with the value of the land which could be sold in case the home were totally destroyed, provide that security. Without a mortgage, the vast majority of homeowners would not have been able to purchase their homes. In light of the essential nature of home insurance, lenders often refer their customers to local insurance agents, or increasingly now offer insurance services themselves. So, as the Seventh Circuit Court of Appeals stated in the 1992 case of *NAACP v. American Family Mutual Insurance Co.*, “No insurance, no loan; no loan, no house; lack of insurance thus makes housing unavailable.”

Households experiencing what the industry refers to as a problem of “insurance availability” are not randomly scattered throughout metropolitan areas. They tend to be located within central city neighborhoods, usually with high concentrations of non-white residents. While some rural communities experience availability problems due primarily to limited fire protection, for a variety of reasons this has been a particularly urban problem. For example, in Milwaukee 72.4 percent of homes in white areas compared to 61.6 percent of homes in black areas were covered by insurers required to comply with that state’s disclosure requirements in 1999. (Very few states have such requirements as will be discussed below.) Remaining homes either have no coverage or are protected by smaller insurers or so-
called “surplus lines” or “off shore” or “non-admitted” insurers. These insurers are not regulated by the states and, therefore, are not included in state guaranty funds which means consumers are not protected if the companies should go bankrupt (Squires, O’Connor, and Silver, 2001).

Urban communities tend to have older homes with electrical, heating, and other major systems that have not been updated in recent years. Older wood frame homes, generally concentrated in cities, pose a greater fire risk than newer suburban brick homes. The dense nature of housing patterns means that a fire on one property may damage a nearby property, leading insurers to avoid high concentrations of policies in a particular neighborhood. Theft rates are higher in many urban neighborhoods than in most suburban communities. Relatively lower valued dwellings in cities also make urban properties less profitable to insure. A recent insurance industry study of loss costs in eight major metropolitan areas between 1989 and 1994 found that the frequency of claims was 18 percent higher in cities than in the neighboring communities within five miles of the city boundaries; there were 124 claims per 1,000 insured homes in the cities compared to 105 claims in the surrounding communities. And the average claim was 20 percent higher in cities. Consequently, industry costs per insured home were 42 percent greater for urban than suburban policyholders (Insurance Research Council, 1997).

But in addition to risk factors that may differ between some cities and suburbs in general, a host of other practices (discussed below) that are not based on risk adversely affect urban communities. Redlining of older urban neighborhoods, including practices of racial profiling and discrimination, exacerbate urban insurance availability and affordability problems. Compounding the racial effect is the fact that racial minorities tend to have lower incomes, live in lower-valued homes, and reside in cities (U.S. Bureau of the Census, 2002). The connection between property insurance practices and the fate of cities was captured by a federal advisory committee in 1968 which observed:

Insurance is essential to revitalize our cities. It is a cornerstone of credit. Without insurance, banks and other financial institutions will not — and cannot make loans. New housing cannot be constructed, and existing housing cannot be repaired. New businesses cannot expand, or even survive.

Without insurance, buildings are left to deteriorate; services, goods and jobs diminish. Efforts to rebuild our nation’s inner cities cannot move forward. Communities without insurance are communities without hope (President’s National Advisory Panel, 1968: 1).

There is a direct line between the actions of the property insurance industry and the critical problems facing the nation’s most distressed urban communities that was captured in the title of one law review article, “Property Insurance and the American Ghetto: A Study in Social Irresponsibility” (Yaspan, 1970). If progress has been made since the federal advisory report in 1968, the problems of urban insurance availability
and affordability, including its racial dimensions, retain their largely urban character. As another legal scholar concluded:

Hardest hit by unavailability and unaffordability difficulties are transitional neighborhoods in older cities and members of minority groups. So long as unavailability and unaffordability problems remain, communities without affordable insurance become communities with diminishing hope (Badain, 1980: 76).

A related reason for the significance of property insurance for cities and the economy in general is the sheer size of the industry. In 2001 total assets of the insurance industry reached $4.2 trillion with the assets of those other than life insurers totaling $881 billion. For all financial services sectors, including banks and securities, total assets were $37.6 trillion. So insurers accounted for just over 11 percent and non life insurers accounted for just over two percent of total assets in financial services (Insurance Information Institute, 2003: 4). In 2000 the property insurance industry (which includes automobile, commercial, marine as well as homeowners insurance) received $299.6 billion in premiums. (Premiums are the dollars collected for policies that are sold.) Homeowners premiums reached $32.4 billion. In 1999 the property insurance industry’s net after-tax income was $20.6 billion. And the insurance industry generally, including life and health insurers as well as property insurers, employed 2.3 million people in the U.S. (Insurance Information Institute, 2002: vii, 60).

Not surprisingly, in 1999 the states that generated the most premiums were primarily large urban states with California ranking first followed by New York, Texas, Florida, and Illinois. Average premiums ranged from a low of $266 in Wisconsin to a high of $861 in Texas. Insurers generally pay out more in losses and loss cost expenses than they collect in premiums. In 2000 property insurers paid out approximately 10 percent more than they received from their underwriting activities. But in most years earnings from invested funds along with money set aside as loss reserves compensate for underwriting losses and enable insurers to generate a profit (Insurance Information Institute, 2002: 14, 64).

The property insurance industry, therefore, constitutes an important actor, economic and otherwise, in urban and metropolitan areas. It is also an integral piece of the institutional infrastructure of inequality in urban and metropolitan areas. The industry reflects and reinforces the role of race and place in framing the opportunity structure confronting residents of the nation’s cities and surrounding communities. The restructuring of American cities in recent decades has been accompanied by growing inequality and concentration of poverty along with a range of social problems associated with those developments (Goldsmith, 2002; Harrison and Bluestone, 1988; Jargowsky, 1996, 2003; Massey and Denton, 1993; Wilson, 1996; Wolff, 1995). If the overt expression of racist sentiments has been subdued, the
continuing reality of racial profiling, grounded in longstanding and persisting racial stereotypes, reveals the ongoing centrality of racism in the political economy of urban communities. Again, the devil is in the details. One of those critical details is the property insurance industry.

From documents describing industry underwriting guidelines and marketing strategies, court documents, as well as research by government agencies, industry and community groups, and academics, the following pages document historical and contemporary practices of racial profiling and related forms of redlining and racial discrimination on the part of the property insurance industry. Such practices incorporate elements of both disparate treatment and disparate impact discrimination that are unlawful under the federal Fair Housing Act and many state statutes. Under the disparate treatment standard plaintiffs must establish that the respondent intentionally discriminated on the basis of a protected class membership (e.g., race, ethnicity, gender). Under the disparate impact standard intent is not necessary. The universal application of an apparently neutral policy or practice that excludes a disproportionate share of protected class members (e.g., racial minorities) would violate the act unless the respondent could establish a legitimate business purpose for that policy or practice and that no lesser discriminatory alternative is available to accomplish that objective (Crowell, Johnson, and Trost, 1994: 158–162). No parallel legal definition of racial profiling has emerged from the legislative debates and court cases in the fair housing area, but given the legal standards that have emerged it clearly incorporates many of the elements of unlawful practices that have been identified.

Following the discussion of past and present profiling and discrimination, successful efforts to combat these practices are reviewed and, as in other chapters, policy recommendations are offered to further reduce the role of race in the delivery of property insurance products and services. Racial profiling may not be as visible within the property insurance industry as it is in law enforcement but insurers are equally proficient, perhaps because they have had so much practice.

The Insurance Industry’s Character Problem: Moral, Morale, and Other Hazards

Insurers generate their revenue from the sale of insurance policies. In so doing they incur a range of costs. In 2000 for each dollar collected in premiums insurers paid 79.6 cents for claims, 25 cents for sales and administrative expenses, 2.5 cents in taxes and 1.3 cents in dividends. As noted above, these costs come to more than 100 percent, which is normal for most insurers’ underwriting activities. Investment income compensates for these losses and permits insurers to generate a profit and continue making insurance available (Insurance Information Institute, 2002: 14). But in order to stay competitive and maximize their returns, insurers need
to determine whether a given applicant is eligible for a policy, and, if so, how much to charge.

The insurance industry has one major problem. It does not know the actual cost of its product (an insurance policy) when the product is sold. This makes the decision to sell a policy, the price at which it should be sold, and other terms and conditions most problematic. Property insurance policies that cover homes are generally sold on an annual basis. A premium or price is charged and is often paid in full at the beginning of the policy period. But the cost to the insurer will not be known until the end of that time period. In most cases there is no measurable damage to the home so no claims are filed and the insurer incurs few expenses other than transaction costs involved in processing the application and premium payments. In other cases the property that is insured is damaged and, on occasion, totally destroyed. These costs are generally far higher than the annual premium that is charged.

So the industry tries to determine in advance who is likely to experience a loss and how large those losses will be, and because it is too expensive to collect information on the unique characteristics of each applicant, the industry categorizes applicants into groups based on expected losses. The industry attempts to identify those attributes that account for losses and which people share those attributes. Actuaries develop risk classifications and underwriters determine in which class a given applicant belongs. Two sets of considerations generally enter into this process: 1) characteristics of the property to be insured and the neighborhood in which it is located and; 2) characteristics of the people to be insured. Compounding the complexities is the fact that decisions by insurers can affect the behavior of insureds. Once a homeowner is insured against a particular risk or event that could cause a loss, the household has less of an incentive to avoid such situations and may take fewer precautions to reduce the chances of such an event occurring.

Several property-related factors affect whether or not an applicant is eligible, and if so under what terms. These include the construction of the dwelling which involves the type and age of materials, the condition of the building, and adequacy of maintenance. For example, a wood frame building is more susceptible to fire than a brick structure so all else equal, a wood home is more expensive to insure. Occupancy, or the purpose for which the home is used, is another factor. If the home is also used for certain types of business use, it might be ineligible for home insurance and the owner would have to seek out a commercial policy. Protection is a third consideration. Presence (or absence) of smoke alarms, security systems and other protective devices can affect eligibility for coverage. Proximity to fire hydrants and the quality of local fire protection services are additional factors. Exposure is another property-related consideration. This refers to hazards or risks in neighboring properties such as certain types of industrial concerns, abandoned lots, or other environmental hazards (Wissoker et al., 1998).
Characteristics of people are also important. The industry identifies two general types of hazards that relate to the character and behavior of applicants and insureds: “moral hazards” and “morale hazards.” The former refers to any condition that increases the likelihood of fraud. Someone who is intent on fraud can pose challenges to an insurer. The industry argues, for example, that someone in financial trouble may be more likely to submit fraudulent claims. Requiring credit reports as part of the underwriting process is justified as part of an effort to learn if the applicant poses such a risk. Some companies will not provide a full replacement cost policy (i.e., a policy that will pay the full cost for repairing or replacing damage resulting from a loss) if the market value of the home is substantially less than its replacement cost. A market value policy might be offered but such a policy covers only the current market value (purchase price less depreciation) of items, which is often insufficient to replace them. The fear is that such an insured has an incentive to burn their house down for the insurance money.

A morale hazard refers to a situation where an insured simply becomes less careful once their property is covered. Though no fraud is intended, knowing that an insurance policy is in force may cause some to be less careful in preventing loss than would otherwise be the case. This problem can be dealt with, at least in part, by offering incentives to take preventive action. For example, discounts can be offered for the installation of smoke alarms or security systems. Deductibles are often included whereby the insured is responsible for at least the first few hundred or thousand dollars of any loss (Heimer, 1982, 1985).

So the challenge for the insurance industry is to identify those characteristics of individual properties and people that are conducive to loss and either avoid them or charge higher premiums. The overriding problem confronting insurers remains the fact that they still do not know the cost of its product when it is sold to the consumer. Race has been used as part of the effort to solve that problem. That is, in addition to the tools noted above, a longstanding practice of the industry has been to use race — both the race of individual applicants and the racial composition of neighborhoods — in efforts to classify and price risks. Where race is associated with loss, insurers may have a financial incentive to engage in “statistical discrimination,” but these practices are illegal nevertheless. It is unlawful to use average characteristics of a racial group to determine whether housing related services will be provided to any particular individual (Yinger, 1995: 67–69). Where race is used but is demonstrably not predictive of loss, there is virtually no justification for such practices. Yet drawing on traditional stereotypes that persist throughout the United States (e.g., racial minorities and particularly blacks are still viewed as less motivated to work, more likely to be engaged in crime — Feagin 2000; Bobo and Massagli 2001; Schuman et al., 1997) racial profiling in the insurance industry has been a fact of life that undercuts economic development opportunities for stigmatized groups and hinders urban redevelopment in general (Badain, 1980; Metzger, 2001; Powers, 1997; Smith and Cloud, 1997;
Yaspan, 1970). Consequently, minorities, particularly those who live in distressed neighborhoods, face the double whammy of race and place.

The Role of Race in Evaluating Risk and Marketing Products

The property insurance industry has long asserted that risk drives underwriting and pricing activity and that race has virtually nothing to do with these practices. Urban insurance availability and affordability, from this perspective, simply reflect the higher losses in those neighborhoods. As indicated above, one study of loss costs in eight major metropolitan areas found that as a result of greater frequency and higher costs of claims in urban communities than in surrounding neighborhoods, urban policyholders cost insurers 42 percent more per policy than did policyholders in nearby neighborhoods (American Insurance Association, 1993; Insurance Research Council, 1997; National Association of Independent Insurers, 1994). Yet race is a factor that has long been explicitly taken into consideration in evaluating risk (Heimer, 1982; Yaspan, 1970) and many industry practices have an adverse disparate impact on minority communities (i.e., result in a higher share of residents in these communities compared to those in white communities that is denied a policy, charged higher prices, or otherwise offered less advantageous terms and conditions) even though no intentional racial considerations may be present (Kincaid, 1994; Powers, 1997).

The following statement by one marketing consultant illustrates the importance of race, and the link between character and race that was widely and openly expressed at least through the 1950s:

It is difficult to draw a definite line between the acceptable and the undesirable colored or cheap mixed white areas; the near west side (Madison Street) and near north side (Clark Street) still attract the derelict or floating elements with "honky tonk," mercantiles and flop houses. Any liability in the areas described should be carefully scrutinized and, in case of Negro dwellings, usually only the better maintained, owner occupied risks are considered acceptable for profitable underwriting (National Inspection Company, 1958).

This statement makes it clear that one of the keys to profitable underwriting was racial discrimination. Apparently, where there are colored or mixed areas it is difficult to determine acceptable from unacceptable areas. And it is the racial composition of such neighborhoods that raises the initial question about acceptability. What is it about race that matters? Apparently, it is the association with derelict behavior. If there is profitable business to
be written for “Negroes” (but apparently not for whites) only well maintained properties in which the owner resides are acceptable.

More recently, through the early 1990s, at least one major insurer used explicit racial stereotypes to identify neighborhoods in Richmond, Virginia, where it avoided writing insurance. Among the neighborhood descriptions found in that company’s marketing guidelines were the following:


In part because of such marketing practices, a jury ruled that Nationwide Insurance Company violated the Virginia fair housing act (Housing Opportunities Made Equal, Inc. v. Nationwide Mutual Insurance Company et al. No. 2B-2704 (Circuit Court, Richmond, VA, Feb. 2, 1999)).

Other labels recently employed by various consultants to characterize different types of neighborhoods that have guided insurers and other financial service providers in their marketing include “Low Income Southern Blacks,” “Middle Class Black Families,” and “Urban Hispanics.” At least one of these firms has dropped the race and ethnic labels, but in ways that reflect a downgrading of those neighborhood clusters. “Middle Class Black Families” was changed to “Working Class Families,” and “Low Income Southern Blacks” was replaced with “Hard Times” (Metzger, 2001). The primary result is that many residents of such areas are offered less attractive products than are available in other communities, in part for reasons that are unrelated to the actual risk they pose. The American Family sales manager quoted at the opening makes it clear that race is important and why; whites work. Again, the role of race in identifying underlying character traits is indicated.

In a 1995 survey of insurance agents in the Lehigh Valley in southeastern Pennsylvania three percent stated that an applicant’s race was a factor in their decision to insure a home. When asked to agree or disagree with the statement “The race of a homeowner is never a factor when deciding whether or not to insure a home,” 94 percent said they “Completely Agree.” When asked about “the racial mix of a neighborhood” 88 percent “Completely Agree” it is never a factor. The vast majority, in other words, state that race or racial composition is never a factor (Community Action Committee of the Lehigh Valley Inc., 1995: 5, 7). Yet more than 25 years after the Fair Housing Act was passed, at least some agents continue to openly endorse the use of race in the underwriting of insurance policies. This finding may well understate the number of agents...
who explicitly take race into account. Survey respondents often give what they perceive to be socially acceptable responses to interviewers that may differ from their true beliefs. When questions are related to race, this generally means providing answers that reflect a more liberal or tolerant attitude than some respondents actually hold (Schuman et al., 1997: 92–98).

In a confidential conversation in 2002 an insurance broker said he was often asked the following two questions, in what he referred to as “verbal underwriting” for multi-family dwellings: 1) is there any Section 8 at these properties; and 2) are the kids in this neighborhood more likely to play hockey or basketball. Both of these questions were understood by this broker, and by others, to be subtle code words to elicit information on the race of the tenants (Luquetta, 2002).

Much of this evidence is anecdotal but there is also quantitative evidence of the systematic use of race, and of practices that have a disparate impact on racial minorities. The National Association of Insurance Commissioners, basically a trade association of state law enforcement officials who regulate the insurance industry, examined the distribution and costs of homeowners insurance policies across 33 metropolitan areas in 25 states in the mid 1990s. Researchers found that racial composition of neighborhood remained statistically significantly associated with the number and cost of policies even after controlling on loss experience and other demographic factors (Klein, 1995, 1997). (For contradictory findings in Texas where the effect of race was not significant, see Grace and Klein, 1999).

Some of the reasons for these disparities have been uncovered by fair housing organizations in audit or paired-testing studies. In these experiments, white and non-white “mystery shoppers” (or shoppers from white and non-white neighborhoods) are assigned the same relevant individual, home, and neighborhood characteristics, and then they contact various insurance agents in their communities posing as householders that are interested in purchasing a policy for their homes. The only difference in each pair is their race or the racial composition of the neighborhood of the home they want to insure. Because each pair is matched on the relevant criteria (e.g., income and occupation of householder, age and construction of home, fire protection ratings of residential neighborhoods) any differences in treatment are assumed to constitute racial discrimination.

Tests of major insurers conducted by several fair housing organizations around the country have routinely found disparities in the way white and non-white testers and neighborhoods have been treated. Where white testers and testers from predominantly white neighborhoods generally have been aggressively pursued as customers, blacks and Hispanics as well as testers from black and Hispanic neighborhoods have confronted many barriers.
Differences include:

- The willingness to provide a policy for whites but denying or referring minority applicants elsewhere;
- Not returning calls from minority testers while promptly responding to whites;
- Offering policies with different terms and conditions (e.g., full replacement cost policies for whites, market value policies for non-whites);
- Charging different prices for the same policy;
- Requiring inspections in non-white but not white areas;
- Requiring non-whites to supply social security numbers (so credit checks could be run) but not soliciting such information from whites.

Between 1992 and 1994 the National Fair Housing Alliance tested major insurers in nine cities and found evidence of unlawful discrimination in the following percentages of tests in the respective cities: Chicago 83 percent, Atlanta 67 percent, Toledo 62 percent, Milwaukee 58 percent, Louisville 56 percent, Cincinnati 44 percent, Los Angeles 44 percent, Akron 37 percent, and Memphis 32 percent (Smith and Cloud, 1997: 108–109).

Similar disparate treatment has been found in approximately half the tests conducted of major insurers by several fair housing organizations (National Fair Housing Alliance, 2000; Smith and Cloud, 1997; Toledo Fair Housing Center, 1999). The one study that attempted to assess the extent of racial discrimination market-wide (rather than among particular insurers as has been the case with most of the insurance testing that has occurred) did not find differences in terms of access to insurance. Researchers with the Urban Institute examined the Phoenix and New York City markets and found that quotes were offered to the vast majority of white, black and Hispanic testers. But in Phoenix Hispanics were slightly less likely to be offered full replacement coverage on the contents of their homes than were whites (92 percent and 95 percent) and were more likely to be told the quote would not be guaranteed without an inspection of the home (3 percent compared to 0.4 percent among testers who contacted the same agents). Quotes were also 12 percent higher for Hispanics, though in line with rates filed with the state insurance commissioner for different rating territories, which raises questions about the validity of those state-approved delineations. And in New York white testers were slightly more likely to receive both a written and verbal quote (18.1 percent) compared to 11.8 percent for blacks who were more likely to receive just a verbal quote. Though not large, these differences were statistically significant (Galster et al., 2001; Wissoker et al., 1998: 3).

Many insurers market their products in ways that, by intent or effect, favor white neighborhoods. The location of agents is one key indicator of
where an insurer intends to do business. A study of agent location and underwriting activity in the Milwaukee metropolitan area found that two-thirds of all policies these agents sold covered homes within the zip code or one which bordered the zip code in which their office was located. Coupled with the fact that the proportion of insurance agents in metropolitan areas located in central cities has consistently declined as their numbers have increased in suburban communities, the location (and relocation) of agents has an adverse disparate impact on the service available in minority communities. In Milwaukee, for example, the number of suburban agents increased from 32 to 297 between 1960 and 1980 while the number in the city initially grew from 113 to 157 during the 1960s but then dropped to 125 by 1980. The ratio of agents per 1000 owner-occupied dwellings remained virtually constant in the city (1.01 and 1.09) while increasing from .34 to 1.25 in the suburbs (Squires, Velez, and Taeuber, 1991). A study of two major insurers within the city of Chicago also revealed a concentration of agents in predominantly white neighborhoods, and an avoidance of non-white neighborhoods, within the city limits (Illinois Public Action, 1993). Housing values, loss experience, and other economic and demographic changes might account for some of this movement. But studies of agent location in the St. Louis and Milwaukee metropolitan areas found that racial composition of neighborhood was associated with the number of agents and agencies even after controlling for various socio-economic characteristics including loss experience, income, housing value, and age of housing (Schultz, 1995, 1997; Squires, Velez, and Taeuber, 1991).

Underwriting guidelines utilized by many insurers have an adverse disparate impact on non-white communities. Restrictions associated with credit history, lifestyle (e.g., prohibitions against more than one family in a dwelling; references to morality, stability), employment history, and marital status are frequently utilized though no “business necessity” has been demonstrated (Powers, 1997). Two commonly utilized underwriting guidelines are maximum age and minimum value requirements. For example, insurers often reject or limit coverage for homes that were built prior to 1950 or are valued at less than $100,000. The disparate impact of maximum age and minimum value guidelines is most evident. In 1999 23.6 percent of owner-occupied housing units nationwide were built prior to 1950. But 30.6 percent of black owner-occupied housing units and 41.7 percent of Hispanic units were built before 1950. And while 46.0 percent of all owner-occupied housing units were valued at less than $100,000, for blacks the figure was 65.5 percent and for Hispanics it was 50.8 percent. Clearly, these two underwriting guidelines exclude a larger share of black and Hispanic households than whites (U.S. Bureau of the Census, 2002.) Practices that exclude a disproportionate share of a protected group may constitute unlawful, disparate impact discrimination even in the absence of evidence of intent to discriminate. These underwriting guidelines may fall in this category and, arguably, would not constitute racial profiling.
But the impact of these underwriting guidelines is foreseeable and, therefore, perhaps the racial effect is not unintentional. Consequently, they comprise part of the complex web of practices that constitutes racial profiling in the property insurance industry.

A related problematic underwriting rule is the moral hazard, noted above, that many insurers assume exists when a property’s replacement value (what it would cost to repair or rebuild a home) exceeds the market value (what it would sell for). For example, if a home would cost $100,000 to rebuild but would sell for only $50,000, the fear is that a homeowner would intentionally burn the home in order to collect the insurance proceeds. Others contend that, despite the apparent incentive, owner-occupants have many social and psychological, as well as financial, investments in their homes and do not present such a risk. The industry itself is split on the question of whether or not homeowners are engaged in any significant arson for profit schemes. Arson has long been a problem in urban communities but it is primarily a problem with commercial rather than personal property. In 1998 arson was reported to be a cause of fires in 10.8 percent of residential and 20.4 percent of non-residential fires. Property damage from arson grew from $1.5 billion in 1991 to $2.4 billion in 1992 and then declined to $1.3 billion in 2000 (Insurance Information Institute, 2002: 92, 96). Arson occurs primarily where property owners have encountered financial difficulties. They may owe back taxes, payments on loans that are overdue, or other debts they are unable to meet. They may have encountered an immediate emergency such as a medical crisis for a family member. But no empirical evidence has been presented to establish that homeowners residing in properties where replacement value exceeds market value are indeed “selling their homes to the insurance industry” (Brady, 1984). Given the neighborhoods where replacement value most often exceeds market value, such an underwriting rule excludes a substantially higher share of homes in non-white than in white neighborhoods (Powers, 1997).

Though clearly an under-researched issue, the claims process is also affected by racial and ethnic stereotypes held by many adjustors. (Adjustors are insurance professionals who evaluate losses and settle claims filed by policyholders (Brenner, 1993: 4)). According to one former adjustor for a major insurer, “black claimants routinely received smaller settlements than white claimants” and her company “routinely set lower reserve amounts for Hispanics than for any other type of claimant” (Saadi, 1987: 55, 58). Her company questioned claims filed by blacks and Hispanics more than those filed by whites, in part because of beliefs that racial and ethnic minorities did not occupy the same occupational status and, therefore, might falsify a claim to get more money or could simply be fooled into accepting less. Lower claims settlements were also justified on the grounds that the medical profession would not provide the same level of care for minorities and, therefore, such claimants could not utilize the funds to the same extent as whites (Saadi, 1987: 55–62).
An examination of claims settled following Hurricane Andrew in south Florida in 1992 concluded that Hispanic claimants were 60 percent less likely than whites to be paid within 60 days of filing after controlling for income and education of claimants and level of damage to homes. A law professor and a sociologist at the University of Miami observed insurance claims mediations and interviewed claimants, adjustors, and mediators. They noted the strong subjective dimension of the claims settlement process and the types of indicators adjustors looked for to identify the likelihood of fraud. Types of neighborhoods people lived in, the cars they drove, their business or professional background, immigrant status, and other social attributes were openly acknowledged by adjustors as factors they take into consideration. Stereotypes adjustors held about immigrants generally and Hispanics in particular led them to be more suspicious of claims from these groups. There was no difference in the claims ultimately paid, just the length of time in paying them, which reinforced the conclusion that untrustworthiness was a major factor underlying the claims adjustment process (Baker and McElrath, 1996, 1997).

There is a contradictory element to these stereotypes. If racial minorities are easier to exploit in the claims process, arguably they would be more profitable (and desirable) customers. But there is no evidence that the industry favors minority applicants on any systematic basis, and it appears just the opposite is the case. Again, limitations in data availability (discussed below) hinder efforts to precisely quantify the role of race in the sale and service of insurance products.

The insurance industry is primarily concerned with risk exposure when it writes policies. But perceptions of race and the places that minorities occupy have long influenced the industry’s methods for assessing and responding to the ambiguous liabilities it assumes when it issues a policy. While debates over redlining and racial discrimination in the property insurance industry have raged for decades, in recent years more aggressive responses have been proposed and in some cases implemented by community organizations, law enforcement officials, and the industry itself.

**From Redlining to Reinvestment?**

Responses to urban insurance availability problems, or redlining and racial discrimination by property insurers, have taken several forms. The NAIC has issued model laws prohibiting what is referred to as “unfair discrimination” and several states have implemented those statutes. But there has been little enforcement. State insurance commissioners basically have been missing in action in the insurance redlining debate. Their activities focus on rate regulation, establishing licensing procedures, reviewing financial statements and determining solvency standards. Their primary concern is to assure that companies remain solvent (Brenner, 1993: 90). Several insurers have launched a range of voluntary initiatives including educational programs, mentoring initiatives, and related
outreach efforts. The most effective responses have come from fair housing organizations that have filed a series of lawsuits and administrative complaints resulting in substantial institutional changes on the part of the nation’s largest insurers. But given the absence of publicly available data on underwriting and marketing activities, it remains unclear how much progress has been made in eradicating the role of race and ameliorating urban insurance availability problems.

Two basic problems have undercut the effectiveness of state insurance commissioners; the absence of political will and the limitation of resources. Those who enforce the law frequently are closely connected to the industry they are charged with regulating. A study of state legislators who are members of insurance committees in ten large states found that almost one-fifth either own or are agents for an insurance business or are attorneys with law firms that have large insurance practices (Hunter and Sissons, 1995). Many state insurance commissioners came from and went to the industry prior to and after their public service as their state’s chief law enforcement officer (Paltrow, 1998). And the resources available at the state level to regulate what are increasingly global corporations are insufficient. To illustrate, as of 1998 13 state insurance commissioners offices employed no actuaries to examine the fairness of rates that companies charged and the states approved. Indiana received 5,278 consumer complaints in 1997 bringing the total for the previous four years to more than 21,000. Disciplinary action was taken against 11 insurers. With a limited staff, most complaints were simply forwarded to the companies against whom the complaints were filed (Paltrow, 1998).

Some states are engaged in a range of educational and outreach activities, often in conjunction with insurers and trade associations. The Neighborhood Reinvestment Corporation created a National Insurance Task Force consisting of several leading insurance companies, state insurance commissioners and trade associations to conduct a range of educational initiatives. Homeowners are advised on loss prevention programs including fire safety, crime prevention, and home maintenance efforts in order to reduce their risk potential and increase their eligibility for insurance. Insurance companies and agents are educated on how to identify good business in urban areas and to market their products in previously underserved communities (Neighborhood Reinvestment Corporation, 1995, 1997).

The Cincinnati based National African American Insurance Association is working with Howard University and the District of Columbia Insurance Commissioner to train minority students for careers in insurance (Mazier, 2001a). The Independent Insurers Association of America and several insurers including Chubb, Safeco, and Travelers have joined in an effort to provide additional support for, and to mentor, minority agents (Mazier, 2001b; Thomas, 1999). These same insurers, along with others,
also have launched formal diversity training to assist their agents to serve and work with minority communities (Ruquet, 2001). Some insurers are simply finding profitable business in neighborhoods they had ignored in the past (Bowers, 1999).

Fair housing organizations have been the most effective vehicle for changing the way property insurers serve urban communities, and minority markets in particular. Since 1995 evidence produced primarily from paired testing audits conducted by non-profit fair housing organizations has led to settlements of administrative complaints and lawsuits, and one jury verdict involving several leading insurers including Allstate, State Farm, Farmers, American Family, Nationwide, Liberty and others. This group represents the four largest, and six of the ten largest, homeowners insurers accounting for half the premiums written in the U.S. market in 2000 (Insurance Information Institute, 2002: 61). As a result of these actions, these insurers have provided financial compensation to plaintiffs, eliminated maximum age and minimum value underwriting guidelines, opened agencies in previously underserved urban neighborhoods, developed educational and marketing campaigns in these communities, and financed future testing as part of an effort to evaluate the effectiveness of these reinvestment efforts. In some of these cases funds have been made available to assist homeownership in urban communities, and in one case an affirmative action plan was implemented to increase employment opportunities for minorities at all levels within the company. Examples include a $17 million commitment by Nationwide for damages and various reinvestment efforts in Richmond, Virginia (Housing Opportunities Made Equal Inc. v. Nationwide Mutual Insurance Company et al. No. 2B-2704 (Circuit Court, Richmond, Va. 1999; Millen and Chamberlain, 2001). American Family negotiated a $14.5 million agreement that included $5 million for plaintiffs and $9.5 million to subsidize loans and grants for home purchase and repair (United States v. American Family Mutual Insurance Company (C.A. No. 95-C-0327 [E.D. Wisc. 1995]), NAACP v. American Family Mutual Insurance Company (978 F.2d 287 [7th Cir. 1992]). Discussions are currently underway with insurers in several cities and more settlements are likely.

An emerging point of contention is the industry’s use of mathematical formulas in which credit scores are systematically used in determining eligibility for, and the price of, insurance policies. While credit information has been used by some insurers for selected applications in the past, now approximately 90 percent of property insurers use credit scores systematically in their underwriting or pricing activities (Ford, 2003). Insurers claim that people with better credit scores are less likely to file claims. It is argued that those who are more careful in the management of their financial assets also will be more careful in their handling of other assets including their homes and automobiles. Because credit scoring leads to more accurate pricing of insurance policies, according to this perspective, the market is more competitive with more companies offering policies.
resulting in greater choices for consumers (American Insurance Association, undated; Snyder, 2003; Texas Department of Insurance 2004). Critics contend that, due to racial disparities in income, debt ratios, bankruptcies, inaccurate credit reports, and other financial matters, the use of credit reports exerts an adverse disparate impact on minority communities and, therefore, constitutes a new form of redlining. One problem is that the data the industry rely on in drawing its conclusions are not available for public scrutiny, making independent verification of its claims difficult (Birnbaum, 2003, 2004; Willis, 2003). One outcome of this debate was the introduction of the 2003 “Insurance Credit Score Disclosure and Reporting Act” in the 107th Congress by Rep. Luis Gutierrez (D-IL). This bill would require insurers to disclose the use of credit scoring to all applicants along with the impact of the credit score on the price of all policies, it would prohibit insurers from taking any adverse action regarding insurance coverage based solely on credit history, it would require insurers to refund premiums calculated on the basis of inaccurate credit information and it provided for additional protections for consumers in the use of credit information.

Despite the wide range and large number of new initiatives, it remains unclear just how differently property insurers are serving older urban communities and racial minorities in particular. A critical piece of a future agenda is the documentation of precisely how effectively various communities are being served.

Beyond Racial Profiling: Future Research and Policy Implications

Thirty-five years ago when financial institutions were widely accused of redlining and racial discrimination, Congress stepped in and enacted three critical pieces of legislation, as discussed in Chapter Two. The Civil Rights Act of 1968 (the Federal Fair Housing Act) banned racial discrimination in mortgage lending. In 1975 the Home Mortgage Disclosure Act (HMDA) required most mortgage lenders to annually disclose the number, type, and dollar amount of loans they made by census tract in all metropolitan areas. The Act has been modified several times and now requires lenders to report the race, gender, and income of all applicants, the disposition of applications (e.g., whether they were approved or denied), and pricing information on selected high-cost loans. In 1977 the Community Reinvestment Act (CRA) provided a federal prohibition against redlining. It places on all federal depository institutions (e.g., banks and savings and loans) an affirmative obligation to ascertain and be responsive to the credit needs of the communities they serve, including low- and moderate-income neighborhoods.
These statutes are widely credited for increasing lending activity in low- and moderate-income communities and for racial minorities in particular, as noted previously (Avery et al., 2005a; Gramlich, 1998, 2002; Joint Center for Housing Studies, 2002; Meyer, 1998). Disclosure, coupled with federal prohibitions, appear to have had the intended effect. No comparable requirements exist for property insurers. The limited disclosure data available have had some salutary effects. A broader, nationwide proposal might do for insurance what HMDA has done for mortgage lending.

A recent survey of all state insurance commissioners solicited information on HMDA-like disclosure requirements that were currently in place. Just eight states had some geographic disclosure requirements, all at the zip code level. Data on individual insurance companies were available in just four of these states. Loss experience and cost information was available at the aggregate level in three states. No state made loss or cost data and pricing information available for individual insurers (Squires, O’Connor, and Silver, 2001).

Despite the limitations of available data, they have proven useful in some instances. Plaintiffs in the American Family case noted above utilized the Wisconsin disclosure data in negotiations that resulted in the $14.5 million settlement including commitments to write at least 1200 new policies and open new offices in Milwaukee’s black community, elimination of maximum age and minimum value underwriting guidelines, $9.5 million in subsidized loans to support home ownership, and other reinvestment initiatives (Lynch, 1997; Ritter, 1997).

In an analysis of 1999 Wisconsin data researchers found that six insurers had a market share in white zip codes that was at least 50 percent larger than their share in black areas. In regressing the percentage of owner-occupied dwellings covered on racial composition, race was negatively and statistically significantly associated with coverage for each insurer. Controlling on income resulted in a statistically significant finding for two insurers, Prudential and Integrity Mutual (Squires, O’Connor, and Silver, 2001). Data on loss experience were not available. Research reported above by Klein (1997) and Schultz (1995, 1997) did control on loss experience because in their capacity as employees of the National Association of Insurance Commissioners and the Missouri Department of Insurance they had access to information not available to the general public. Independent investigation of Prudential by fair housing organizations found that this insurer utilized maximum age and minimum value underwriting rules that adversely affected minority neighborhoods, placed relatively few agents in minority communities, refused to provide African American and Hispanic callers with the same level of information provided to white callers, and took other actions that made insurance less available in minority neighborhoods in Milwaukee, Philadelphia,
Racial Profiling, Insurance Style

Richmond, and Washington, D.C. A formal fair housing complaint was filed and is currently pending (National Fair Housing Alliance v. Prudential, Case Number 1:01CV02199, U.S. District Court for the District of Columbia, 2001).

From a public policy perspective, the logical next step is to enact a federal disclosure requirement for property insurers modeled on HMDA. Such a requirement would call for insurers to publicly report, on an annual basis, information on applicants, properties, and neighborhoods including: the race, gender, and income of applicants; type of policy and amount of coverage applied for; replacement value of home; disposition of those applications; price of policy; census tract in which the property is located; structure (e.g., brick or frame) and age of home; number of rooms and square feet of home; number and severity of claims; and distance to nearest fire hydrant.

Such disclosure would allow for far more comprehensive understanding of which, if any, markets were underserved and would facilitate, in particular, understanding the extent to which race remains a factor. This information could assist insurers in their marketing strategies. It would help state insurance commissioners target scarce enforcement resources. And it would help community organizations identify potential partners for reinvestment initiatives. As John Taylor, Executive Director of the National Community Reinvestment Coalition, observed regarding disclosure in mortgage lending, “The mere act of data disclosure motivated partnerships among lending institutions, community organizations, and government agencies for designing new loan products and embarking on aggressive marketing campaigns for reaching those left out of wealth building and homeownership opportunities” (National Community Reinvestment Coalition, 2001b).

Many fair housing and community development advocates, along with some policymakers, also have endorsed CRA-like requirements for the insurance industry. The proposed Community Reinvestment Modernization Act of 2001 (H.R. 4893, 106th Congress, 2nd Session, which has been introduced in subsequent years but not enacted), would establish an affirmative obligation for insurers to provide insurance products and investment activity in low- and moderate-income neighborhoods, along with comprehensive disclosure of where such services were being offered. Massachusetts requires insurers to invest in low-income communities in exchange for tax relief offered by that state. California has created a voluntary program in which community groups bring investment opportunities to the insurance commissioner who attempts to attract commitments from insurers in that state to finance those projects (Luquetta and Goldberg, 2001).

These are baby steps, however, relative to what lenders have been doing for decades and what appears to be the needs of many low-income and particularly minority neighborhoods. Again, absent systematic disclosure, it is difficult to identify areas of greatest need or appropriate
intervention strategies. State regulators currently have the necessary data or the authority to collect them but few have demonstrated a desire to do so. Social reform frequently bubbles up from the local level to states and the federal government. In light of the history of racial profiling and redlining in the property insurance industry, the contentious nature of responses, and the questions that persist, the time appears ripe for a federal insurance disclosure requirement.

Despite the limitations of current data availability, there is substantial anecdotal and quantitative evidence that indicates the persistence of racial profiling, discrimination, and redlining on the part of property insurers. But the fundamental causes of these problems extend far beyond the insurance industry. The specific policies and practices that have been identified are firmly grounded in stereotypes that continue to permeate the United States. A number of regulatory, legislative, and voluntary industry initiatives could ameliorate racial profiling and discrimination within the property insurance industry. But more meaningful progress in combating these industry-related problems may await more progress in addressing the problems of stereotyping and discrimination in American society generally.

Research on racial attitudes demonstrates that white Americans continue to view blacks as being less intelligent, less hardworking, and more prone to criminal behavior than whites (Feagin, 2000: 109–140). When asked to account for racial disparities, lack of motivation on the part of blacks is the argument with the greatest appeal among whites. Their problems would be largely solved if they worked harder, according to this dominant perspective. Whites exhibit little recognition of past or present discrimination as a factor blocking black progress (Schuman et al., 1997: 155–170). Such beliefs reflect and reinforce patterns of inequality leading to structured or institutionalized racial inequalities that often appear to be inevitable if not natural outcomes of intrinsic cultural characteristics (Bobo and Massagli, 2001). Concerns with work and morality on the part of insurance agents, underwriters, and others simply reflect stereotypical attitudes that transcend any one industry.

Once formed, stereotypes, and the structured inequalities they generate, change slowly. If there is a kernel of truth to stereotypes (e.g., black unemployment is higher than white unemployment) there is a tendency to paint everyone in the group with the same broad brush. People respond to labels, and their stereotypical images of those to whom the label has been attached, rather than to individuals in those groups. This results in sweeping misjudgments that have critical racial and spatial consequences (Bobo and Massagli, 2001). Racial segregation, the uneven development of metropolitan areas characterized by urban sprawl and concentrated poverty, and the associated social costs are just some of those consequences (Orfield, 1997, 2002; Rusk, 1999). For an industry like insurance that depends on risk classifications and the categorization (influenced by stereotypes) that this entails, the negative consequences are magnified.
One kernel of truth may well be that some urban neighborhoods pose greater risks to insurers than other neighborhoods that are not underserved. Insurers may be responding to signals of the marketplace in their underwriting and pricing decisions. But to the extent that objective measures of risk explain the industry’s behavior, a key question is why various neighborhoods pose different risk levels. To the industry, such uneven development is largely a reflection of the culture, morality, and behavior of residents with race being a major determinant. Rarely does the industry point to disinvestment by private industry, fiscal crises of municipalities, public policy decisions that have long favored suburban over urban communities (e.g., federal highway construction, exclusionary zoning laws, mortgage deductions and other subsidies for home ownership), steering by real estate agents, subjective and discriminatory property appraisals and many others (Gotham, 2002; Jackson, 1985, 2000; Massey and Denton, 1993). Given these structural realities and subjective stereotypes of the industry, eventually the prophecy becomes self-fulfilling. So it becomes “rational” to avoid some minority communities. But this reflects the “crackpot realism” Mills wrote about more than forty years ago (Mills, 1958: 185–6). Such behavior is rational, only given the larger irrationality of private practices and public policies that have nurtured uneven development (Dreier, Mollenkopf, and Swanstrom 2001). As the evidence cited earlier indicates, however, the industry is not responding just to risk. Race appears to have an independent and adverse impact even after loss experience, risk, and other objective measures are taken into account (Klein, 1997; Schultz, 1995, 1997).

Racial profiling persists in the insurance industry and it leads to unlawful disparate treatment and disparate impact discrimination and exacerbates uneven development and racial inequality generally. This dynamic is grounded in unflattering racial stereotypes that reinforce these structural dimensions of inequality. Profiling and discrimination may be less pervasive today than in previous decades, or these practices may simply be more subtle. Progress appears to have been made in recent years in part from “universalistic” approaches like loss mitigation and other educational efforts directed at urban consumers and insurers generally. (The broader ongoing debate between universalistic and race-specific policies is discussed in the concluding chapter). But racial disparities resulting from both objective economic factors and subjective discriminatory practices continue and, to be effective, proposed remedies should be mindful of the overt and subtle racial dynamics. The necessary data do not exist to draw precise conclusions regarding the extent to which objective and subjective considerations drive these decisions. Insurers will always face the problem of not knowing the actual costs of its product when that product is sold but steps can be taken to maximize the extent to which such decision-making is predicated on actual risk and minimize the role of race.
Insurance unavailability or unequal terms and conditions on which insurance is available, can deny homeownership before a family even has applied for a mortgage loan to buy a home. Insurance redlining denies homeownership particularly in better neighborhoods, forcing families to seek housing in less desirable communities characterized by inferior education, limited opportunities for employment, exposure to crime and other indicators of distress. These patterns reinforce the links among race, place, and privilege. While insurance has been subjected to far less inquiry and policy debate than other housing and financial services issues, this chapter shows that insurance plays a critical gatekeeping function in the distribution of privilege.

The fact that racial discrimination persists in the insurance industry does not deny the fact that compensable losses do occur, or to suggest that they are randomly distributed throughout metropolitan areas. A major cause of loss is crime, a problem which is concentrated in particular neighborhoods. Insurers have long worked with law enforcement authorities and others in attempt to mitigate criminal activity. But most of their attention has been on what innocent individuals and households can do to reduce their chances of being a victim or increase opportunities for ex offenders to find more productive outlets for their activities. Lost in virtually all debates over what to do about crime are actions that institutional actors can take to reduce crime. The following chapter examines the role that financial institutions, which have long provided the underpinnings for home ownership and business development, can take to reduce crime through community reinvestment initiatives.
References


Racial Profiling, Insurance Style


Toledo Fair Housing Center v. Farmers Insurance Groups of Companies.

1999. Case No. CI0199901339 Common Pleas Court of Lucas County.


John Robst*

Abstract

This paper examines premium growth between 1998 and 2000 for Medigap insurance coverage. Weiss Ratings, Inc. (2001) reported that between 1998 and 2000, premiums for plans that cover prescription drugs increased 37.2%, while premiums for plans without prescription benefits increased 15.5%. However, the computation of average premiums did not take into account the market share of the insurers. This paper weights premium growth by Medigap plan enrollment to account for market share. Medigap premiums increased faster for plans with a prescription drug benefit, but the difference was much smaller than previously reported. For enrollees age 75, premiums for non-prescription plans increased 15.2% while premiums for prescription plans rose 19.6%. Large premium increases tended to occur with smaller insurers, limiting the impact on the premiums paid by beneficiaries.

Introduction

Medigap supplemental insurance enables many Medicare beneficiaries to reduce their financial risk. While Medicare benefits are extensive, like many insurance products, the program has deductible and coinsurance requirements, as well as limitations on payments to providers. On average, basic Medicare benefits cover 45% of the personal health care expenditures of aged beneficiaries in the United States (Kaiser Family Foundation, 2005). Because of these gaps in coverage, many beneficiaries also are covered by supplemental policies provided by employers or purchased individually. About 89% of Medicare beneficiaries have some form of supplemental insurance, with

* Research associate professor, Department of Mental Health Policy and Law, Louis de la Parte Florida Mental Health Institute, University of South Florida; jrobst@fmhi.usf.edu.
23% of beneficiaries covered by individually purchased Medigap plans (Laschober, 2004).

Given the importance of Medigap coverage for the elderly, the Centers for Medicare & Medicaid Services (CMS) contracted for the creation of a comprehensive database on Medigap premiums. Using these data, Weiss Ratings, Inc. (2001) reported average premiums charged by insurers in 1998 and 2000 for each of the 10 standardized plans. Between 1998 and 2000, premiums for plans that cover prescription drugs increased 37.2%, while premiums for plans without a prescription drug benefit increased 15.5%. The substantial increase in premiums for drug coverage was attributed to rising drug prices.

Rising drug prices are unlikely to explain such rapid premium growth, because standardized Medigap plans that cover drugs have substantial co-payments and caps on benefits. One potential additional explanation for such rapid premium growth is that the costs for non-drug benefits were also increasing for individuals enrolled in the prescription drug plans. However, while considering a slightly different time frame (1996–1998), the American Academy of Actuaries (2000) found that claim trends for non-drug costs were lower than for drug costs in plans H, I and J. Such results imply that the premium increase for drug policies can primarily be attributed to rising drug costs, not the cost for the non-drug benefits. However, as noted above, it is unlikely that rising drug prices explain the reported increase in premiums.

One potential problem with the Weiss analysis involves the computation of premium growth. Average premiums were computed for 1998 and 2000, with premium growth computed as the percentage increase. However, the computation of average premiums did not take into account the market share of the insurers. An insurer covering a few people has the same weight when computing averages as AARP/United HealthCare and the Blue Cross Blue Shield plans, which together account for more than 60% of the market. As such, the Weiss results represent the average premium charged by insurers, not the average premium paid by beneficiaries. Regulators have greater reason for concern when price increases occur throughout the market or when firms with substantial market share increase prices. If price increases are limited to firms with small market share, such increases are unlikely to affect many beneficiaries or be maintained.

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1. The Weiss Ratings press release received national exposure in a USA Today article on supplemental insurance (Appleby, 2001). The New York Times also reported that premiums for Medigap plans covering prescription drugs were increasing rapidly due to rising prescription drug prices (Freudenhaim, 2001).
This paper re-examines premium growth between 1998 and 2000 for Medigap supplemental insurance coverage. Specifically, market share is accounted for by computing enrollment-weighted premium growth. Medigap premiums increased faster for plans with a prescription drug benefit, but the difference was much smaller than previously reported. Large premium increases tended to occur with smaller insurers, limiting the impact on the premiums paid by beneficiaries.

Background

Medicare is the primary health insurance for most seniors. Under traditional fee-for-service Medicare, beneficiaries are responsible for 20% of Part B physician-allowed charges and a Part B deductible. Also not covered under basic Medicare are deductibles and co-payments for hospital stays up to 90 days per episode of care (there may be multiple episodes in a year), co-payments during a lifetime reserve of 60 additional days of inpatient care, all costs beyond the 150-day limit (or 90 days if the lifetime reserve has been exhausted), co-payments for some skilled nursing facility (SNF) services and limited costs for other services. In addition, with the introduction of Medicare drug coverage in 2006, patient liability for outpatient prescription drugs ranges from very little for those qualifying for low-income subsidies to 100% of costs for those not purchasing Part D coverage.

Since 1992, newly issued Medigap policies have been required to conform to one of 10 standardized benefit packages. The benefits offered under each plan in 2005 are summarized in Table 1. As discussed below, numerous changes were made to the Medigap program in 2006. Thus, the discussion of plan benefits is based on options prior to 2006 to reflect the 1998-2000 time frame under consideration. Plans H and I offer a limited prescription benefit. After a $250 deductible, 50% of prescription costs are covered, up to a maximum of $1,250. Plan J has a more extensive prescription drug benefit, covering up to a maximum of $3,000.
### Table 1
**Standardized Medigap Plans — 2005**

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plan Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Type</strong></td>
<td>A</td>
</tr>
<tr>
<td><strong>Basic Benefits</strong></td>
<td>X</td>
</tr>
<tr>
<td>$228 per day coinsurance for days</td>
<td></td>
</tr>
<tr>
<td>61-90 in hospital</td>
<td></td>
</tr>
<tr>
<td>$456 per day coinsurance for days</td>
<td></td>
</tr>
<tr>
<td>91-150 in hospital</td>
<td></td>
</tr>
<tr>
<td>Payment in full for 365 additional</td>
<td></td>
</tr>
<tr>
<td>hospital days</td>
<td></td>
</tr>
<tr>
<td>20% part B coinsurance</td>
<td></td>
</tr>
<tr>
<td>3 pints of blood</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital deductible</strong></td>
<td>X</td>
</tr>
<tr>
<td>$912 per hospitalization</td>
<td></td>
</tr>
<tr>
<td><strong>SNF coinsurance</strong></td>
<td>X</td>
</tr>
<tr>
<td>$114 a day coinsurance for days</td>
<td></td>
</tr>
<tr>
<td>21-100 in SNF</td>
<td></td>
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<tr>
<td><strong>Foreign travel emergencies</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Part B deductible</strong></td>
<td>X</td>
</tr>
<tr>
<td>$110</td>
<td></td>
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<tr>
<td><strong>Home health care</strong></td>
<td>X</td>
</tr>
<tr>
<td>Home health aide after SNF care</td>
<td></td>
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<tr>
<td>Maximum $40 per visit for 40 visits</td>
<td></td>
</tr>
<tr>
<td><strong>Part B excess charges</strong></td>
<td>X</td>
</tr>
<tr>
<td>Difference between doctor’s charge and</td>
<td></td>
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<tr>
<td>Medicare’s approved charge (up to 115%</td>
<td></td>
</tr>
<tr>
<td>of approved charge)</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>X</td>
</tr>
<tr>
<td>$120 per year for preventive care</td>
<td></td>
</tr>
<tr>
<td><strong>Basic prescription</strong></td>
<td>X</td>
</tr>
<tr>
<td>50% of outpatient drugs (after a</td>
<td></td>
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<tr>
<td>$250 deductible)</td>
<td></td>
</tr>
<tr>
<td>Maximum $1,250 benefit per year</td>
<td></td>
</tr>
<tr>
<td><strong>Extended prescription</strong></td>
<td>X</td>
</tr>
<tr>
<td>Same as basic, but maximum annual</td>
<td></td>
</tr>
<tr>
<td>benefit of $3,000</td>
<td></td>
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</tbody>
</table>


The Medigap program is undergoing changes. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) suggested that the NAIC consider restructuring benefits in standardized Medigap plans. The MMA also created two new Medigap plans (K and L). The plans have basic benefits similar to those offered in plans A through G, except that instead of paying 100% of the Medicare cost-sharing requirement, the plans pay 50% to 75%. The plans have annual out-of-pocket limits: $4,000 for Plan K and 2,000 for Plan L. Once the annual limit is met, the plan pays 100% of the
Changes in Medigap Supplemental Insurance Premiums

Medicare Part A and Part B co-payments and coinsurance for the rest of the calendar year. In addition, the MMA created a Medicare prescription drug benefit, and eliminated sales of new Medigap plans that cover drugs. Individuals enrolled in plans H, I and J may keep such coverage, but are ineligible to participate in the Medicare prescription drug program. Despite the substantial changes that have taken place, it is important to understand trends in prescription drug premiums as the insurance industry and Medicare beneficiaries adjust to program reforms.

Insurers use three different premium rating methods: attained-age, issue-age and community-rated. Attained-age premiums are based on current beneficiary age, while issue-age premiums are based on the beneficiary's age when initially covered under the Medigap plan. A few states (e.g., Florida and Georgia) require issue-age rating. Community-rated premiums are the same for all individuals in the same geographic area regardless of age. Several states (i.e., Arkansas, Connecticut, Maine, Missouri, Washington and New York) require that premiums be community-rated.

There are additional Medigap policies that insurers may sell and/or service. Medicare Select policies offer lower premiums, but limit the insured's choice of providers (Lee, et al., 1997; GAO, 2001). However, the vast majority of insurers do not offer Medigap Select policies for plans H, I and J. Insurers may offer plans F and J with deductibles, which also lower the premiums charged to enrollees. In 2005, individuals acquiring prescription coverage by purchasing Plan J with deductibles had to pay a $1,730 deductible (plus the $250 prescription deductible) before any drugs were covered. Plans originally sold prior to July 1992 are not required to conform to the standardized benefit packages. Pre-standardized plans account for 33% of the Medigap covered lives in 1999, with ad hoc evidence suggesting that up to 40% of these plans have some form of drug coverage. Massachusetts, Minnesota and Wisconsin have alternative standardized plans in place of the national standardized plans, with the alternative plans including an optional prescription drug benefit. Wisconsin requires insurers to provide a catastrophic drug benefit that covers 80% of prescription drugs above $6,250 in all Medigap plans.

Ten years after legislation standardized Medigap plans, Fox, Snyder and Rice (2003) found that the use of standardized plans is supported by consumers, and has decreased insurer and agent abuses. On the other hand, loss ratios have changed little and access to coverage for disabled beneficiaries is often problematic. They also found that premiums increased markedly over time. Between 1994 and 2000, premiums increased 81% for Plan C, 51% for Plan F and 77% for Plan I, with no clear difference between drug and non-drug plans. However, generalizability of these results might be questioned, because data were included from only five states (Florida, Missouri, New York, Texas and Washington), three of which require community rating.
Data

CMS contracted for the creation of a comprehensive database on premiums charged by insurers for newly issued policies. While this information is generally available through state insurance regulators, local/state aging offices and directly from Medigap insurers, a comprehensive listing of premiums by plan type, beneficiary age/sex group and geographic area was not available. Data collection occurred in several steps. First, letters were sent directly to insurers requesting premium data. Approximately 40% of the data were collected during this stage. Second, letters were sent directly to state insurance departments requesting premium data. This step was least productive, accounting for only 10% of the data. After these steps, it was decided that a considerable number of insurers were still unaccounted for in the database. Thus, visits were made to each state insurance department to collect missing data. Collection of the remaining half of the data occurred during this stage.

The database contains variables denoting the state\(^2\), insurer, plan type (A-J), rating method (attained-age, issue-age or community-rated), whether the policy is underwritten or guaranteed issue, Select or non-Select, and for smokers or non-smokers. Observations contain information on premiums paid by state residents in the years 1998 and 2000 for a newly issued policy, with premiums reported separately by gender and age. For example, an insurer selling Plan A with attained-age rating that was guaranteed issue, non-Select, for non-smokers has an observation for each state in which the insurer sold the policy. Within a state, an insurer has one observation for each combination of policy characteristics. We use premiums reported for three ages: 65, 75 and 85. The three states (Massachusetts, Minnesota and Wisconsin) exempt from selling the standardized plans are excluded from the analysis.

While this database represents a substantial improvement over prior data on Medigap premiums paid by beneficiaries, no information was collected on the number of lives covered by each policy. As discussed earlier, it can be problematic to compute average premiums without accounting for market share. Data are available from the NAIC’s Medigap experience files on the number of covered lives by insurer, state, standardized plan and whether a Medigap Select policy. The match between the premium database and the NAIC data was not complete, with approximately 30% of the premium observations not having a corresponding observation in the NAIC data. Such premiums may indicate insurers gained approval for rates from state insurance regulators but did not actively market the plan. Non-matching observations are

\(^2\) All 50 states plus the District of Columbia are represented in the database.
excluded from the analysis because the number of covered lives could not be determined.³

There are several assumptions implicit in using the NAIC data on covered lives to measure market share. For example, while the database contains premiums for newly issued policies in 1998 and 2000, the NAIC data report the total number of lives covered by a policy regardless of when it was originally issued. The number of covered lives is assumed to be correlated with the number of newly issued policies.⁴ For example, AARP/United HealthCare covers many Medigap enrollees, but also sells many new policies. Also, while premiums are available by age and gender, only total covered lives are provided — and it is assumed that the relative distribution of age and gender groups is constant across insurers. Still, despite shortcomings, the NAIC data represent the best available source of information on covered lives, and we expect that using covered lives is much closer to the true weight (new policies sold by age and gender group) than weighting each observation equally when computing averages. The final sample contains 6,731 observations in 1998 and 6,193 in 2000.⁵

---

³. Given the high number of non-matches, we examined whether there are systematic differences between the matches and non-matches in 1998. A logit regression is estimated on a pooled match/non-match sample with “match” as the dependent variable. There was no difference in match rates across the states, nor did matching depend on whether the policy was guaranteed issue. Attained-age and issue-age policies had slightly lower match rates than community-rated policies. Non-matches increased as (unweighted) premiums increased. The relationship between the match rate and premiums is potentially problematic for this paper, and is addressed in more detail in the results section. Compared to Plan J, matches were more likely for plans C, F, G and I, but less likely for plans D, E and H. Non-matches were slightly more likely among plans covering fewer people (D and E) and least likely among the most popular plans (C and F). This is consistent with the hypothesis that some non-matches are due to insurers gaining approval for rates but not actively marketing the plans and, thus, having no covered lives.

⁴. One alternative would be to measure the number of policies sold as the difference in covered lives between 1997 and 1998. Such a measure captures the net change in covered lives, but undercounts the number of new policies because some people covered in 1997 were not covered under the same policy in 1998. Another option is to use the NAIC variable denoting the number of policies issued over the 1996-1998 period. The correlation was .94 between the log of policies issued 1996-98 and the log of total covered lives. Similarly, the rank order correlation was .9 between policies issued in 1996-98 and total covered lives. This provides further support that insurers who cover more people tend to issue more new policies.

⁵. The NAIC does not report separate data for smoking and non-smoking policies. When an insurer reported smoking and non-smoking rates, 90% of the covered lives were attributed to the non-smoking premium and 10% to the smoking premium. The distribution is based on Centers for Disease Control and Prevention (CDC) data on smoking rates among the elderly.
Methodology

The analysis is conducted in several steps. First, because Weiss Ratings did not merge the database with the NAIC data, their analysis included the non-matching observations excluded in this paper. Thus, the first step is to determine whether different results are generated simply due to sample composition. As such, we compute unweighted average premiums by plan type, compute premium growth from the unweighted premiums and compare them to the results reported in the Weiss analysis.

Second, the weighted average premiums paid by beneficiaries are computed for the years 1998 and 2000. Premium growth computed using weighted average premiums is compared to the unweighted results to determine the effect of weighting observations by the number of covered lives.

However, even weighted averages may be problematic because premiums change for a variety of reasons. For example, there has been a trend by the states to require insurers to use community rating, which has significant effects on premiums. Thus, it is important to control for changes in policy characteristics when examining premium growth. A fixed-effects regression specification is estimated to control for policy characteristics:

\[ \text{Premium}_{it} = X_{it} \cdot \beta + Z_{it} \cdot \delta + I_{it} \cdot \alpha + \varepsilon_{it} \]

where \( i \) is policies, \( t \) is the year, \( X \) is a vector denoting each standardized plan, \( Z \) is the state variables, \( I \) is insurers and \( \varepsilon \) is a normally distributed error term. A fixed-effects specification controls for unobserved differences across insurers and states. Observations are weighted by the number of covered lives to account for differences in the number of policies sold. Separate regressions are estimated for 1998 and 2000, with premium growth calculated as the relevant \( \beta_{2000} \) minus \( \beta_{1998} \) for each standardized plan.

Results

Unweighted Premium Growth

Table 2 contains premium growth from Weiss Ratings (2001) and from the matched premium NAIC Medigap sample. There are some minor differences in the unweighted results due to sample composition. Premiums for non-drug plans increased 15.5% in the Weiss analysis and 14.9% in the matched sample, while prescription plan premiums increased 37.2% in Weiss and 35.6% in the matched sample. Despite the minor differences, using the matched sample does not have a substantial effect on the unweighted results.
Table 2
Unweighted Premiums Increases by Plan Type, 1998-2000

<table>
<thead>
<tr>
<th>Plan</th>
<th>Weiss Ratings</th>
<th>Unweighted Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>21.4%</td>
<td>18.1%</td>
</tr>
<tr>
<td>B</td>
<td>17.3</td>
<td>14.5</td>
</tr>
<tr>
<td>C</td>
<td>16.4</td>
<td>15.9</td>
</tr>
<tr>
<td>D</td>
<td>16.6</td>
<td>16.1</td>
</tr>
<tr>
<td>E</td>
<td>14.9</td>
<td>15.3</td>
</tr>
<tr>
<td>F</td>
<td>11.8</td>
<td>12.4</td>
</tr>
<tr>
<td>G</td>
<td>9.8</td>
<td>9.6</td>
</tr>
<tr>
<td>Non-prescription Plans</td>
<td>15.5%</td>
<td>14.9%</td>
</tr>
<tr>
<td>H</td>
<td>49.3</td>
<td>50.6</td>
</tr>
<tr>
<td>I</td>
<td>34.4</td>
<td>37.8</td>
</tr>
<tr>
<td>J</td>
<td>27.3</td>
<td>22.6</td>
</tr>
<tr>
<td>Prescription Plans</td>
<td>37.2%</td>
<td>35.6%</td>
</tr>
</tbody>
</table>


Weighted Average Premiums

The 1998 and 2000 weighted average premiums paid by beneficiaries are provided in Table 3, with premiums reported separately by plan type and age (65, 75 and 85). The majority of insurers offer plans A, B, C and F, but relatively few insurers offer the plans that include prescription drug coverage (H, I and J). Before looking at the premium changes over time, premium differences across policy characteristics are discussed. To conserve space, the focus is on 1998 premiums, while noting that similar differences exist for 2000.

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6. While premiums charged to men and women are reported separately, there is no statistically significant gender difference in premiums. To conserve space, this paper does not make a distinction between the premiums charged to men and women.
### Table 3
Weighted AveragePremiums Based on Policy Characteristics

<table>
<thead>
<tr>
<th>Plan</th>
<th>Observations</th>
<th>1998</th>
<th>2000</th>
<th>Change (in $ and percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65</td>
<td>75</td>
<td>85</td>
<td>65</td>
</tr>
<tr>
<td><strong>Non-prescription Plans</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>1285</td>
<td>738</td>
<td>809</td>
<td>860</td>
</tr>
<tr>
<td>B</td>
<td>862</td>
<td>1084</td>
<td>1209</td>
<td>1237</td>
</tr>
<tr>
<td>C</td>
<td>1188</td>
<td>1110</td>
<td>1287</td>
<td>1400</td>
</tr>
<tr>
<td>D</td>
<td>522</td>
<td>923</td>
<td>1211</td>
<td>1400</td>
</tr>
<tr>
<td>E</td>
<td>27</td>
<td>1001</td>
<td>1151</td>
<td>1214</td>
</tr>
<tr>
<td>F</td>
<td>1273</td>
<td>1090</td>
<td>1363</td>
<td>1534</td>
</tr>
<tr>
<td>G</td>
<td>558</td>
<td>1030</td>
<td>1245</td>
<td>1369</td>
</tr>
<tr>
<td>Total</td>
<td>5959</td>
<td>1013</td>
<td>1209</td>
<td>1320</td>
</tr>
<tr>
<td><strong>Prescription Plans</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>195</td>
<td>1725</td>
<td>1804</td>
<td>1824</td>
</tr>
<tr>
<td>J</td>
<td>366</td>
<td>1546</td>
<td>1712</td>
<td>1761</td>
</tr>
<tr>
<td>J</td>
<td>211</td>
<td>1855</td>
<td>2150</td>
<td>2277</td>
</tr>
<tr>
<td>Total</td>
<td>772</td>
<td>1733</td>
<td>1946</td>
<td>2029</td>
</tr>
<tr>
<td><strong>Rating Method</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attained-age</td>
<td>3971</td>
<td>1278</td>
<td>1483</td>
<td>1728</td>
</tr>
<tr>
<td>Issue-age</td>
<td>1847</td>
<td>1149</td>
<td>1463</td>
<td>1578</td>
</tr>
<tr>
<td>Community-rated</td>
<td>913</td>
<td>1107</td>
<td>1108</td>
<td>1108</td>
</tr>
<tr>
<td><strong>Select</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6368</td>
<td>1264</td>
<td>1376</td>
<td>1524</td>
</tr>
<tr>
<td>Yes</td>
<td>363</td>
<td>905</td>
<td>1166</td>
<td>1242</td>
</tr>
<tr>
<td><strong>Guaranteed Issue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6197</td>
<td>1239</td>
<td>1375</td>
<td>1435</td>
</tr>
<tr>
<td>Yes</td>
<td>534</td>
<td>1143</td>
<td>1285</td>
<td>1353</td>
</tr>
<tr>
<td><strong>Tobacco</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6344</td>
<td>1257</td>
<td>1366</td>
<td>1524</td>
</tr>
<tr>
<td>Yes</td>
<td>387</td>
<td>957</td>
<td>1187</td>
<td>1396</td>
</tr>
</tbody>
</table>

Premiums paid for Medigap insurance increase with age. Premiums also vary considerably across the 10 plans, with higher premiums paid for plans that offer prescription drug benefits. Approximately 59% of the observations are for attained-age policies, while only 14% are community-rated. Attained-age policies are the least expensive for younger (i.e., 65) individuals, but attained-age premiums are similar to issue-age policies for older (i.e., 85) enrollees. Issue-age policies are more expensive at age 65 because the premiums incorporate future increases in utilization as the individual ages, while attained-age premiums are only based on current utilization. The premium difference falls as individuals age because future utilization becomes less relevant. Community-rated policies are relatively expensive for individuals age 65 because younger enrollees subsidize the premiums of older beneficiaries.

Premiums are lower for Medigap Select plans due to the limited provider network. Interestingly, average premiums are lower for guaranteed issue plans than underwritten plans and, among individuals age 65, for policies that...
explicitly cover smokers. Premiums are expected to be lower for policies underwritten or for smokers because insurers are able to screen out sicker individuals (outside open enrollment periods).

**Premium Changes between 1998 and 2000**

Table 3 also reports premium changes between 1998 and 2000 based on the weighted average premiums. For individuals age 65, premiums paid for Medigap coverage increased 16.4% between 1998 and 2000, with premium growth varying across plans. Premiums for plans covering prescription drugs rose between 18.5% (Plan H) and 20.2% (Plan I), well below the unweighted results reported by Weiss Ratings (2001) and in Table 2.

There is no clear difference in premium growth between younger and older enrollees. Premiums increased more rapidly for older enrollees purchasing plans A, B and H, but premiums grew more rapidly for younger enrollees buying plans D, E, F and J. Premium changes for the remaining plans (C, G and I) are not related to age.

Premium growth differed across other policy characteristics. Premiums paid for policies covering smokers grew much more rapidly than for non-smokers. Premiums for Medigap Select policies increased at a slightly lower rate than non-Select policies. The difference in premium growth for underwritten and guaranteed issue plans is substantial, with premiums for underwritten plans increasing more rapidly. Premium growth also differed across rating methods, with premiums for community-rated policies growing more rapidly than for issue-age policies.

**Regression Results**

Regression results allow for the comparison of premium growth in drug and non-drug plans, while controlling for differences in policy characteristics. Premium growth rates are slightly lower across prescription and non-prescription plans. Among the more popular plans (A, B, C and F), premiums increased between 8.8% (Plan F) and 13.1% (Plan C). Premiums grew more rapidly for plans that cover prescription drugs, with premiums increasing 16.8% for Plan H, 18.2% for Plan I and 18.4% for Plan J. The slightly lower premium growth is due to the increasing prevalence of two characteristics associated with rapid premium growth (i.e., guaranteed issue policies and issue-age rating). Thus, some of the weighted average premium growth is due to policy characteristics associated with rapid premium growth becoming more common.
<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>2000</th>
<th>Percent Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>65  75  85</td>
<td>65  75  85</td>
<td>65  75  85</td>
</tr>
<tr>
<td>Plan A</td>
<td>300.7  552.4  694.7</td>
<td>338.7  652.8  832.5</td>
<td>12.6%  18.2%  19.8%</td>
</tr>
<tr>
<td></td>
<td>90.9  123.5  180.4</td>
<td>110.7  163.0  190.7</td>
<td></td>
</tr>
<tr>
<td>Plan B</td>
<td>507.1  800.6  982.5</td>
<td>568.0  897.6  1069.7</td>
<td>12.0%  12.1%  19.9%</td>
</tr>
<tr>
<td></td>
<td>91.3  124.1  181.2</td>
<td>111.3  163.8  191.6</td>
<td></td>
</tr>
<tr>
<td>Plan C</td>
<td>736.1  1061.5  1190.1</td>
<td>832.7  1221.9  1431.8</td>
<td>13.1%  15.1%  20.3%</td>
</tr>
<tr>
<td></td>
<td>91.2  123.9  181.0</td>
<td>111.1  163.6  191.4</td>
<td></td>
</tr>
<tr>
<td>Plan D</td>
<td>551.2  855.0  976.2</td>
<td>618.2  997.9  1197.8</td>
<td>12.2%  16.7%  22.7%</td>
</tr>
<tr>
<td></td>
<td>91.3  124.0  181.3</td>
<td>111.4  163.9  191.7</td>
<td></td>
</tr>
<tr>
<td>Plan E</td>
<td>518.9  811.1  915.2</td>
<td>641.5  999.2  1187.8</td>
<td>23.6%  23.2%  29.8%</td>
</tr>
<tr>
<td></td>
<td>91.6  124.5  181.8</td>
<td>111.6  164.4  192.3</td>
<td></td>
</tr>
<tr>
<td>Plan F</td>
<td>798.6  1154.7  1284.9</td>
<td>868.9  1289.9  1502.5</td>
<td>8.8%  11.7%  16.9%</td>
</tr>
<tr>
<td></td>
<td>61.2  123.9  180.9</td>
<td>111.1  163.6  191.3</td>
<td></td>
</tr>
<tr>
<td>Plan G</td>
<td>610.3  926.9  1046.8</td>
<td>663.0  1037.9  1245.5</td>
<td>8.6%  12.0%  19.0%</td>
</tr>
<tr>
<td></td>
<td>91.8  124.7  182.2</td>
<td>111.9  164.7  192.6</td>
<td></td>
</tr>
<tr>
<td>Plan H</td>
<td>1157.5  1500.7  1617.4</td>
<td>1351.7  1756.2  1964.9</td>
<td>16.8%  17.0%  21.5%</td>
</tr>
<tr>
<td></td>
<td>91.9  124.8  182.3</td>
<td>112.0  164.8  192.8</td>
<td></td>
</tr>
<tr>
<td>Plan I</td>
<td>1257.7  1675.9  1831.5</td>
<td>1487.1  1972.9  2215.5</td>
<td>18.2%  17.7%  21.0%</td>
</tr>
<tr>
<td></td>
<td>91.6  124.5  181.9</td>
<td>111.7  164.4  192.4</td>
<td></td>
</tr>
<tr>
<td>Plan J</td>
<td>1633.1  2116.9  2315.7</td>
<td>1933.3  2466.8  2766.7</td>
<td>18.4%  16.5%  19.5%</td>
</tr>
<tr>
<td></td>
<td>91.6  124.4  181.8</td>
<td>111.6  164.3  192.2</td>
<td></td>
</tr>
<tr>
<td>Issue Age Rated</td>
<td>188.8  86.0  -9.6</td>
<td>247.4  184.8  46.0</td>
<td>31.0% 114.9% 579.2%</td>
</tr>
<tr>
<td></td>
<td>8.9  12.1  17.7</td>
<td>11.0  16.2  18.9</td>
<td></td>
</tr>
<tr>
<td>Community-rated</td>
<td>219.2  -196.9  -388.9</td>
<td>336.7  -122.3  -370.9</td>
<td>53.6%  37.9%  4.6%</td>
</tr>
<tr>
<td></td>
<td>12.3  16.7  24.6</td>
<td>15.3  22.5  26.6</td>
<td></td>
</tr>
<tr>
<td>Guaranteed Issue</td>
<td>174.7  254.9  263.2</td>
<td>204.9  280.5  306.5</td>
<td>17.3%  10.0%  16.5%</td>
</tr>
<tr>
<td></td>
<td>8.6  11.7  17.1</td>
<td>10.7  15.5  18.1</td>
<td></td>
</tr>
<tr>
<td>Medicare Select</td>
<td>-238.3  -346.7  -432.0</td>
<td>-238.7  -349.3  -413.0</td>
<td>-0.2%  -0.7%  4.4%</td>
</tr>
<tr>
<td></td>
<td>7.6  10.3  14.9</td>
<td>9.0  13.3  15.5</td>
<td></td>
</tr>
<tr>
<td>Tobacco</td>
<td>52.8  56.7  71.3</td>
<td>105.6  140.4  170.5</td>
<td>100.0% 147.6% 139.1%</td>
</tr>
<tr>
<td></td>
<td>33.1  44.9  65.6</td>
<td>25.8  38.0  44.4</td>
<td></td>
</tr>
<tr>
<td>R-squared</td>
<td>0.9278  0.9046  0.8603</td>
<td>0.9272  0.8884  0.8812</td>
<td></td>
</tr>
</tbody>
</table>

Note: The specification also includes insurer and state categorical variables.
Premiums increased more rapidly for older enrollees than younger individuals. Both community-rated and issue-age policies became relatively more expensive compared to attained-age policies. As expected, guaranteed issue premiums increased relative to underwritten policies. Thus, underwriting allows insurers to control costs by screening potential enrollees. Premiums for Medigap Select policies increased at the same rate as non-Select plans. While limited provider networks allow insurers to reduce costs relative to a non-Select plan (hence the lower premiums for Select plans), costs are increasing in both Select and non-Select plans. Premiums for smokers grew at a faster rate than for non-smokers.

**Discussion**

This paper shows that premiums increased more for Medigap plans that cover prescription drugs than for plans without prescription coverage. However, the difference is smaller than previous reports that premiums for plans covering prescription drugs grew 2.4 times as fast as premiums for other plans (Weiss, 2001). For enrollees age 75, premiums for non-prescription plans increased 15.2%, which is similar to previous estimates. However, this paper finds that premiums for prescription plans rose 19.6%. Thus, premiums for plans with a prescription drug benefit increased 1.3 times as fast as premiums for non-prescription plans. The smaller difference found when using weighted averages suggests that premiums rose more rapidly for prescription drug plans offered by insurers with small market share.

To confirm this hypothesis, the sample was divided into two groups based on the number of lives covered. The group of insurers with small market share had much larger premium growth for prescription drug plans than insurers with large market share. For example, smaller insurers offering Plan I increased premiums 45% between 1998 and 2000, while larger insurers increased premiums 18%.

The rapid rise in premiums for small insurers suggests that their future ability to offer prescription drug policies would be limited. If such premium increases occurred across all insurers, then consumers interested in purchasing Medigap plans with drug coverage would have to pay the higher premiums. However, there appears to be some degree of competition in the market, with larger insurers offering lower premiums. The rapid increase in premiums would further reduce market share among small insurers, resulting in smaller risk pools and eventually an exit from the market, at least for plans H, I and J. This appeared to have happened, as Weiss Ratings (2002) announced in August 2002 that some insurers had quit offering Medigap drug policies. Future work should confirm that firms exiting the market had a small market share. In addition, Weiss (2002) reported that premiums for plans I and J fell between

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7. The reported results are based on dividing the sample into two groups based on the 75th percentile for covered lives. Alternative groups of smaller and larger insurers produced similar results.
Removing high price observations from a simple unweighted average will reduce “average” premiums. But such a reduction would not affect many consumers because the insurers leaving the market sold only a few policies. Once again, to inform regulators, research should examine the average premium paid by beneficiaries, not the average charged by insurers.

As an additional check of our results, the estimated premium growth for drug policies was compared to prescription drug spending growth in the Medicare Current Beneficiary Survey (MCBS). Given that the American Academy of Actuaries (2000) found that rising drug claims contributed more to premium growth than non-drug claims, we determined whether premium growth was consistent with increases in drug spending. While it would be preferable to examine drug claims incurred by Medigap insurers, we do not have such data. CMS reported the distribution of drug spending for several years of MCBS data (CMS data downloaded on September 20, 2005 is available from author). Two changes are made to the distribution to determine the growth in drug spending relevant to Medigap premiums. First, we eliminate observations below $300. It seems unlikely that many people with such low expenditures would purchase Medigap plans that offer drug coverage. In addition, expenditures are capped at $2,750, the maximum subject to a Medigap benefit. The average drug expenditures grew 19.8% after imposing these restrictions, quite consistent with the 19% to 20% increase in weighted premiums, and well below the amount required to justify the 37% increase reported by Weiss (2001).

While the premium increases for prescription and non-prescription plans were more similar than previously thought, they are still substantial. For example, between 1998 and 2000, the Consumer Price Index for medical care services increased 6.6% for physician services, 13.1% for outpatient services and 10.3% for prescription drugs (BLS, 2001). Price increases for outpatient services and prescription drugs are perhaps most relevant to Medigap premiums, because inpatient benefits are based on Medicare deductibles and

As noted by a referee, the MCBS could be used to directly measure changes in drug spending for individuals covered by Medigap policies. The MCBS is somewhat problematic for assessing drug expenditures for subgroups of individuals (e.g., Medigap enrollees). Poisal and Murray (2001) note that respondents often do not know how much a drug costs. In such cases, a discounted AWP is assigned as the cost. In addition, even if the respondent appeared to know, Poisal (2003) found that prescription drug expenditures are understated by 17% in the MCBS. Underreporting varied considerably across people, and was more common among people with drug coverage. Such errors would increase the variance in prescription expenditure growth substantially for small samples (e.g., Medigap enrollees with a drug benefit). Thus, growth in drug expenditures for all Medicare beneficiaries is used as a comparison in this paper. It is, however, acknowledged that prescription expenditure growth for all beneficiaries may not be highly correlated to growth for Medigap enrollees with drug coverage.
coinsurance, which are not directly related to the rate of inflation. The premium increases for Medigap supplemental coverage, including prescription drug coverage, are greater than the increases in medical care prices, suggesting that utilization of services and prescription drugs also rose. Such a result is consistent with Berndt (2001), who argues that utilization is a more important determinant of increasing pharmaceutical spending than prices, and figures reported by CMS that suggest spending is increasing much faster than prescription drug prices.

Conclusion

This paper examined changes between 1998 and 2000 in premiums paid by beneficiaries for Medigap insurance coverage. Premiums have increased faster than the rate of inflation, but contrary to previous reports, premiums for plans that cover prescription drugs did not increase substantially faster than premiums for plans without drug benefits. Premium growth for Medigap plans offering drug coverage was consistent with the increase in per capita spending on prescription drugs.
References


Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change*

Mila Kofman, J.D.**
Karen Pollitz, M.P.P.***

Introduction

Health insurance serves several public policy goals: It enables consumers to spread the risk of health care expenses and provides them access to medical services that they might otherwise not be able to obtain. Because of the importance of health insurance to the general public welfare, states have been regulating private health insurance companies and products since the late 19th century. State insurance regulation has sought to promote several policy objectives, such as ensuring the financial solvency of insurance companies, promoting the spread of risk, protecting consumers against fraud and ensuring that consumers are paid the benefits that they are promised.

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** Associate research professor and project director at Georgetown University Health Policy Institute; mk262@georgetown.edu.

*** Project director, Georgetown University Health Policy Institute.
The federal government has historically respected the state’s role in regulating insurance. In 1944, the U.S. Congress explicitly recognized this role in the McCarran-Ferguson Act, which said “the business of insurance … shall be subject to the laws of the several States ….”¹ Since the early 1970s, however, the federal government has taken a more active role in areas of insurance regulation that traditionally had been reserved to the states. In 1974, the federal government became the primary regulator of health benefits provided by employers. And in the 1980s and ’90s, Congress established minimum national standards for group health insurance.

This paper provides an overview of the current regulation of health insurance, including a discussion of state and federal standards, regulation and oversight.² It then reviews three Congressional proposals to change health insurance regulation, largely by altering the current balance of federal and state regulatory roles.

Health Insurance Regulation Today

States remain the primary regulators of insurance companies and insurance products. There are, however, a few federal standards that apply to job-based medical benefits. Part A of this article discusses state regulation of insurance. Part B of this article focuses on federal standards, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which for the first time established a national minimum standard for certain health insurance products.³

State Regulation: Types of Standards for Health Insurance Coverage

Every state has adopted certain basic standards for health insurance that apply to all types of health insurance products. For example, all states require insurers to be financially solvent and capable of paying claims. States also require prompt payment of claims and other fair claims-handling practices.

Other aspects of health insurance regulation, however, vary by state and by the type of coverage purchased. Although most states have passed “patient protections” like access to emergency services and specialists, the

standards vary. For instance, 42 states and the District of Columbia had external review laws in 2001. These various appeals programs established different standards concerning the types of disputes eligible for review, fees for the review, deadlines for filing appeals and the selection and qualification of external reviewers.

Other types of state health insurance regulations that vary by state can be grouped as follows: access to health insurance, rating and covered benefits.

Access State policymakers have sought to improve access to health insurance for small businesses and individuals using several regulatory approaches. Absent legislative interventions, in a private health insurance market, insurers adopt practices that seek to minimize their risk in order to avoid losses, including denial of coverage for applicants who have health conditions or a history of health problems. An estimated 10% of individuals account for about 70% of health care spending. Avoiding even a small number of high-cost individuals can substantially reduce an insurer’s losses.

Guaranteed Issue “Guaranteed issue” laws prohibit insurers from denying coverage to applicants based on health status. In the small group market, all health insurance policies must be sold on a guaranteed-issue basis. Historically, this was not the case; generally, states allowed commercial insurers to not sell to groups with medical needs. In many states, however, Blue Cross and Blue Shield plans offered coverage on a guaranteed-issue basis. In the 1980s, the market became more fragmented, and commercial

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4. Other patient protections include “network adequacy” requirements. For example, if a policy promises to cover cancer but there is no oncologist in the plan’s network, then the promise to cover cancer is illusory. State network adequacy laws address this by requiring an appropriate specialist to be in the network. Some states also require that such specialist be located in close proximity to a person’s home or work (to prevent the problem of having to drive long distances — e.g., 200 miles or more — to see a specialist).


7. The private health insurance market is largely a “for profit” market, with some of the largest companies publicly traded on the New York Stock Exchange. These companies have an obligation to their shareholders to operate in ways that maximize profits, which means avoiding the risk of loss. Not-for-profit insurers must also minimize losses. To stay solvent, not-for-profit companies cannot insure only sick people absent government subsidies. In addition, not-for-profit companies must compete with for-profit companies for “good” risks.
carriers became more selective in who they would cover. In response (see guaranteed renewability below), many states enacted guaranteed-issue laws that required all insurers to offer at least two health insurance policies to small businesses regardless of the medical conditions of the employees or their dependents. By the mid-1990s, 36 states had such requirements. In 1996, this requirement became a federal law when the U.S. Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) and required all insurers to sell all their small group policies on a guaranteed-issue basis.

In the individual health insurance market, five states require insurers to sell coverage on a guaranteed-issue basis. Other states have limited guaranteed-access requirements (for example, only for HIPAA-eligible individuals or others with prior continuous coverage). A handful of states require open enrollment periods during which insurers may not deny coverage due to a medical condition.

Guaranteed Renewability Guaranteed renewability laws prohibit insurers from canceling or nonrenewing coverage on the basis of medical claims or diagnosis of an illness. By the mid-1990s, 46 states had such requirements in the small group market. Following HIPAA, all group and individual

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10. Lucia, Kevin and Karen Pollitz, “Summary of Key Protections in Individual Health Insurance Markets (2004),” Health Policy Institute, Georgetown University, available at www.healthinsuranceinfo.net. Guaranteed-issue laws have varied widely among the states, resulting in consumers in some states having more protections than consumers in other states. In many states, however, people with medical needs (even minor ones) find that no insurer would sell them coverage in the individual market, even when they can afford the premiums.
11. HIPAA has a limited requirement that provides access to individual coverage to certain qualified individuals. The coverage may be through a state high-risk pool or through a private health insurance company. To qualify, an individual must have had 18 months of continuous coverage (without a 63-day break); the most recent coverage must be through a group health plan (job-based insurance); may not be eligible for other coverage, Medicare or Medicaid; and must take and exhaust COBRA coverage if eligible for it.
12. In addition, the states have implemented other programs. Thirty-three states have high-risk pools for people with medical conditions. In 2004, these pools covered approximately 180,000 people. Comprehensive Health Insurance for High-Risk Individuals, 19th ed., 2005. Fergus Falls, MN: Communicating for Agriculture & the Self-Employed.
13. For individual policies, many states prohibit a practice called “reunderwriting,” meaning that insurers may not target sick people for rate hikes at renewal, requiring premium increases to be spread among all insured people.
health insurance policies must be guaranteed renewable. Although HIPAA does not prohibit insurers from canceling all their policies and leaving the market, there is a penalty on market re-entry of five years.

**Unfair Marketing Practices Requirements** States also have developed standards to prevent insurers from circumventing guaranteed-issue and renewability requirements. For example, state marketing standards require insurers to actively market policies to all small businesses, not just those with healthy workforces. Federal law does not provide for these kinds of fair marketing requirements.

**Guaranteed Access for Special Populations** States have also passed laws to improve access to health coverage for “special populations.” For instance, most states prohibit insurers from canceling insurance for dependent adult handicapped children who were covered by their parents’ policies as minors. In all states, newborns are automatically covered under their parents’ policy for 30 days, provided that the policy covers dependents.\(^{15}\)

**State Continuation Laws** State policymakers also have enacted coverage continuation laws similar to the federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA). These state laws apply to policies purchased by small businesses not subject to the federal COBRA. Thirty-eight states have such laws; some offer shorter periods of continuation coverage, while others are more generous than COBRA.\(^{16}\)

**Rating** Most states have enacted rating reforms in the small group market, prohibiting or restricting the ability of insurers to charge higher premiums based on health status or the risk of having future medical claims. Some states have enacted similar laws for the individual market. Generally there are two types of restrictions on insurers: rate bands and community/adjusted community rating.

**Rate Bands** Rate bands limit how much insurers can vary premiums for each policyholder based on the health and claims of the policyholder. These limits force insurers to spread some risk more broadly across all policyholders.\(^{17}\)


\(^{17}\) Absent rate restrictions, insurers’ “experience rate” without limitations. That is, each person is charged a premium that reflects one’s claims and medical needs, without spreading those costs among a broader group of people.
The extent to which premiums can vary under rate bands depends on the size of the rate band permitted and what factors are constrained by the band. For example, a model rating law for the small group market adopted by the National Association of Insurance Commissioners (NAIC) in the early 1990s (and since replaced) provided for rate bands that permit premium variation up to 200% based on health status. Also, the model act allowed further variation based on age, gender, industry, small business group size, geography and family composition. Rates based on adjustments for these factors had to be actuarially justified but were not limited except for industry, which was limited to a 15% variation.

The old NAIC model act permitted a wide variation in rates, allowing for a price difference of 26 to 1, or more.\(^{18}\) That is, an insurer could charge a business or person $100 per month — or up to $2,600 per month — for the same policy, depending on risk and other factors. Higher rates under the model would be permitted as long as there was actuarial evidence to support wider variations.

Thirty-seven states have enacted rate bands for coverage sold to small businesses (See Attachment A). Of these, four states follow the original NAIC model act’s restrictions on health-based rating and industry. The rest have modified their approach, applying different limits on insurers’ ability to charge rates based on medical needs, industry, employer’s size, age, gender and/or other factors. A few allow broader variations in premiums based on medical needs. For example:

- Eleven states limit or prohibit insurers from varying rates for small businesses based on the employer’s size;
- Twelve states limit or prohibit insurers from varying rates for small businesses based on the gender of members of the small group; and
- Eight states limit variations based on the age of the workers in small businesses.

At renewal, rate bands also limit how much insurers can surcharge a group or individual based on claims made in the prior year or other factors, such as the length of time (duration) since the policy was first purchased. The renewal surcharge permitted by the rate band, typically 15%, is applied in addition to any increase that would otherwise apply to all policyholders due to the cost of medical care (called “trend”).

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\(^{18}\) NAIC Small Employer Health Insurance Availability Model Act, adopted in 1990. For information on rate variations permissible under the model, see the NAIC Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance.
Community Rating  Community rating means that insurers must set prices for policies based on the collective claims experience of everyone with the same policy (and in theory, the price reflects the value of the benefits, and not the risk factors, of people who purchase the policy). Insurers are not allowed to vary rates based on the health or claims of a business or a person. Under adjusted or modified community rating, premiums may be adjusted based on geographic location and sometimes for a person’s age; adjustments for gender are generally not allowed. At renewal, premiums are based on the claims experience of all people with that policy. In other words, businesses and individuals who had claims are not charged higher rates than others with the same policy.

Shortly after adopting its original model with rate bands, the NAIC replaced it with a model law for small groups that requires adjusted community rating, prohibiting premium surcharges based on health or other risk characteristics. The current NAIC model act limits premium surcharges based on age to 2:1; it prohibits insurers from varying small group premiums based on the gender of people in the group or an employer’s size.

Today, 12 states follow the current NAIC model act. Ten states require all insurers to use community rating or adjusted community rating for all small group policies. Two others, Michigan and Pennsylvania, require Blue Cross and Blue Shield plans (their largest insurers) and HMOs to use adjusted community rating.

Rate regulation that spreads risk is, by nature, redistributive — and so, not without controversy. Critics of rate regulation argue that it raises premiums for healthy individuals and groups higher than they otherwise would pay in the absence of regulation. Advocates of tighter rate regulation note that these rules protect consumers from dramatic premium increases when they are sick, or at renewal after they become sick. There is evidence in support of both points of view. For example, one study found that average health insurance premiums are somewhat higher in community rated markets, reflecting the relatively greater ability of older and sicker people to afford coverage. Another study of rating practices in unregulated

19. The community rate may be different for different insurance companies. That is, the community rate is based on claims experience (plus administrative costs, profits, etc.) of people enrolled with that insurance company (rates adjusted for covered benefits).
markets found rate variation of more than nine-fold (monthly premiums of $183 vs. $1,765) for the same policy based on age and health status.22

The variety in rating rules across states reflects the challenges policymakers have faced in balancing these tradeoffs. States also change rating practices over time in response to changing market and political circumstances. For example, New Hampshire recently restored adjusted community rating in its small group market, having previously repealed it. When adjusted community rating was repealed and replaced by rate bands, many small businesses with older and sicker workers experienced significant premium increases. Legislators responded by reinstating adjusted community rating to spread the cost of any one small employer group’s health experience more broadly.23

**Covered Benefits** States have a wide range of standards that govern the types of conditions and treatments a policy is required to cover (called mandated benefits). For example, in 46 states health insurers are required to either cover (or offer to cover) benefits for diabetes supplies and education.24 Twenty-seven states require insurers to cover cervical cancer screening.25 Fifty states require coverage for mammograms and 32 require coverage for well-baby care (childhood immunizations and visits to pediatricians).26 Mandated benefits also include requirements on insurers to reimburse certain types of medical providers, such as nurse practitioners. The term “mandated benefits” is also used to describe state laws requiring coverage for special populations; e.g., adult handicapped children.

One way to spread the cost of a medical condition or treatment among a broad population, making it less expensive for the group of people who need such coverage, is through a benefit mandate. It is also a way to encourage people to seek certain care (e.g., preventive services) that otherwise may not be received. In the absence of mandates, adding optional

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26. Id.
benefits to a policy can distort premiums if people who need that benefit select the coverage. As an example, in the 1990s, Washington state required insurers to sell comprehensive policies covering all mandated benefits, but also allowed the sale of policies that did not cover certain benefits, like maternity and mental health care. All policies, regardless of covered benefits, had to be sold on a guaranteed-issue basis and were subject to community rating. By 1998, premiums for policies that covered maternity and mental health benefits were anywhere from 30% to 100% more expensive than policies that excluded those two benefits. The choice in benefit design led consumers to self-segregate based on their health care needs, with adverse selection fueling the disparity in premiums for the products (See Attachment B).27

Policymakers make tradeoffs, balancing higher premiums with the need to help finance certain illnesses. How mandated benefits add to the cost of health insurance has been an issue of longstanding controversy. The answer depends in large degree on the extent to which mandates spread the cost of a particular health care service over a large number of policyholders. A recent study found that exemptions from mandates would lower premiums by 5%.28

Interaction of State Regulation and Other Programs to Expand Health Coverage In addition to market rules, some states subsidize private health insurance. State programs have been developed to help expand access to private health insurance by addressing affordability problems. These programs include tax credits and premium assistance, purchasing alliances and reinsurance mechanisms. In 2002, for example, nine states had premium assistance or direct coverage programs, most for moderate- and low-income people.29 A program established in 2005 in Montana offers tax credits and premium assistance to small businesses and workers. Arizona, California, Montana, New Mexico and New York have purchasing alliances for small businesses to negotiate favorable rates and coverage with private insurance companies on behalf of participating

businesses. Reinsurance programs to subsidize high-cost claims have been tried in 21 states. One of the largest programs is Healthy New York, covering approximately 100,000 people in New York state; it uses public funding to subsidize a portion of high-cost claims.

While these state coverage expansion efforts vary, they share a common need for market stability. The cost to states of subsidizing private coverage can quickly become prohibitive if insurers can avoid or shed the most expensive risks or steer them to subsidized coverage. States have adopted various mechanisms, including rating rules and standardized benefit packages, to limit adverse selection against these coverage expansion programs.

State Oversight and Enforcement Tools

Insurance regulators use a number of tools to protect insurance consumers and to oversee and enforce market rules. Some are designed to prevent problems from arising in the first place. For example, states have requirements for who can establish and manage an insurance company (including background checks and a prohibition on convicted felons). Other tools help regulators detect and correct non-compliance with market rules.

Form and Rate Filing State requirements to file policies (called form filings) with the insurance department are designed to prevent insurers from selling non-compliant products. Filed policies are reviewed to ensure they cover required benefits, provide for appropriate appeals and grievance procedures, and meet other state requirements. Rate filings help regulators monitor prices to ensure that premiums are set in accordance with state law and to try to prevent significant rate increases by ensuring that initial rates are adequate to fund future claims.

30. For information about Arizona, New Mexico and California’s programs, see Kofman, Mila, “Issue Brief: Group Purchasing Arrangements: Issues for States,” State Coverage Initiatives, April 2003, available at www.statecoverage.net/pdf/issuebrief403.pdf. Maine also has a program similar to a purchasing pool, called Dirigo. Among its many features, it helps pay for the cost of private health insurance for moderate-income wage earners insured through the program. The coverage is through a private insurer. Funding for the program partly comes through Medicaid.


Market Conduct and Financial Examinations 

Through market conduct exams (periodic or targeted audits of insurers designed to look at a specific practice or suspected problem), states can identify operational problems (such as failure to pay claims fairly or promptly) and other non-compliance with state law. Regulators also conduct periodic or targeted financial exams to look for signs of financial problems in order to prevent or mitigate insolvency.

Corrective Actions 

Tools available to state insurance regulators to ensure corrective action by insurers include fines, administrative “cease and desist” orders and revocation of licenses that authorize insurers to operate in the state. Administrative authority of state regulators allows for quick resolution of problems by avoiding the need to go to court. Licensing is the ultimate enforcement mechanism, as well as a deterrent for insurers to refrain from repeatedly violating the state’s consumer-protection laws. In every state, a company must be authorized to engage in the business of insurance and, thus, the loss of that authority means the insurer cannot do business in that state.

On the financial side, regulators can order an insurer to cease new enrollment. Insurance departments can also initiate receiverships or conservator actions, which means the insurance department takes over the company and either tries to rectify its financial problems or shuts it down. States have established safety nets designed to protect consumers in case of an insurer insolvency. State guaranty funds are non-profit organizations created by statute and financed by insurers in the market to pay the claims of insolvent insurers. All states have such funds. In case of HMO insolvencies, some states require HMOs to have “hold harmless” clauses with their providers, meaning that providers are not allowed to bill patients for HMOs’ bills in cases of insolvency.

General Prohibition on Unfair Practices 

State insurance departments’ consumer services divisions seek to help consumers who are having problems with their insurer or who have general questions about insurance. Through broad authority that regulators have under “unfair claims settlement” and “unfair trade practices” laws, regulators can investigate and require corrective action by insurers engaged in inappropriate practices even when such actions are not explicitly prohibited by state law.

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Federal Legislative Interventions: ERISA, COBRA and HIPAA

As a result of a 1974 federal law called the Employee Retirement Income Security Act (ERISA), health benefits offered by private employers are not regulated by the states. ERISA, however, does allow the states to regulate health insurance policies that employers may purchase. However, employers that self-insure are not subject to state regulation. The types of state consumer protections discussed above do not apply to job-based health coverage offered by employers that self-insure.35

Congress has adopted some substantive standards for employer-sponsored group health plans. Most of these have been incorporated into ERISA and the federal tax code.

The most significant standards were added by COBRA in 1986 and by HIPAA in 1996. COBRA applies to employers with 20 or more employees and gives workers and their dependents a right to continue job-based coverage under certain circumstances. The continued coverage can last 18 to 36 months depending on the qualifying event.

In 1996, the U.S. Congress passed HIPAA to improve access to health insurance and to prohibit discrimination against people with medical needs. Generally, HIPAA set a minimum federal floor of consumer protections to apply to all private health insurance (with exceptions for state and local government employers). Congress allowed more protective state laws to continue to apply.36

Many of these provisions were based on state insurance reforms. HIPAA established national standards for health insurance sold to employers, prohibiting insurers from denying coverage to small businesses, limiting use of preexisting condition exclusions from coverage, prohibiting discrimination based on health and requiring guaranteed renewability. HIPAA standards apply to insurers and group health plans (including those offered by employers that self-insure, which are exempt from state insurance laws). HIPAA also established rights for people leaving job-based coverage, ensuring qualifying people access to individual coverage regardless of existing medical conditions. For both group and individual market coverage, HIPAA left it up to the states to decide whether and to what degree to regulate premiums insurers might charge groups with high medical needs.

Enforcement of HIPAA and related standards involves the states and the federal government. The states have had an opportunity to enact laws that provide at least the protections that are in federal law, and most have


36. For the most part, there are no federal benefit mandates. There are standards, however, that apply when plans provide coverage for mental health, maternity or mastectomies. See Mental Health Parity Act (MHPA), Newborns’ and Mothers Health Protection Act (NMHPA) and Women’s Health and Cancer Rights Act (WHCRA).
done so. Congress relied on the states to adopt and enforce national insurance standards, in part because the federal government does not have personnel or administrative capacity to regulate insurance on a broad scale. However, the U.S. Department of Health and Human Services (HHS) was given authority to enforce federal standards in those states that chose not to enact these protections and in those that are not substantially enforcing similar protections. In other words, HHS became a back-up enforcer to the states. In the early implementation of HIPAA, HHS had to devote federal enforcement resources in states that did not adopt and enforce HIPAA standards.

The U.S. Department of Labor (DOL) continues to have authority over ERISA-covered employers providing benefits, and the U.S. Department of the Treasury has enforcement authority over employers through their tax-qualified group health plans.

**Federal Proposals: H.R. 525, H.R. 2355, S. 1955**

Three bills pending in the 109th Congress propose approaches to health insurance regulation that would depart from current law and change the role of states and the federal government:

- **H.R. 525**, the “Small Business Health Fairness Act of 2005” introduced by Rep. Sam Johnson (R-TX), would federalize regulation of association health plans. It passed the U.S. House of Representatives in July 2005; a companion bill, S. 406, was introduced in the Senate by Sen. Olympia Snowe (R-ME), chair of the Senate Committee on Small Business and Entrepreneurship.


- **S. 1955**, the “Health Care Marketplace Modernization and Affordability Act” was introduced in 2005 by Sen. Michael Enzi (R-WY), the new chair of the Senate Health, Education, Labor, and Pensions (HELP) Committee. S. 1955 would federalize regulation of fully insured association health plans. It would also create new

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38. Public Law 104-191, adding sections 2721, 2722 and 2723 to PHSA.

federal standards for all other health insurance and establish new
parameters within which states would be allowed to regulate health
insurance products and companies. The bill was approved by the
HELP Committee March 15, 2006.

Under all three bills, Congress would limit state regulatory authority,
although each bill adopts a somewhat different approach and the scope of
affected health insurance also varies.

Small Business Health Fairness Act of 2005 (H.R. 525)

H.R. 525 would federalize regulation of health coverage sold through
associations and preempt state laws from applying to association health
plans (AHPs). This would change current law, which requires association
health plans to comply with state laws and, in some cases, with ERISA.

The bill seeks to make health insurance more affordable for small
businesses by allowing them to band together, through associations, to
negotiate for better options with insurers and to achieve cost savings
through exemptions from state insurance laws.

To qualify, health coverage must be sponsored by a trade, an industry
or a professional association (like a chamber of commerce), and must meet
specified standards in the bill. AHPs would be allowed to offer fully insured
and self-insured health benefits. Fully insured AHPs buy health insurance
from state-licensed insurance companies; insurers are responsible for
paying the medical bills. Self-insured plans collect contributions from
enrollees into a fund, paying medical claims out of the fund. Self-insured
AHPs would have to meet federally established solvency requirements in
the bill. Federal standards would be lower than current state-based
requirements applicable to self-insured multiple employer welfare
arrangements (MEWAs).

The U.S. Department of Labor (DOL) would be responsible for
oversight. Once certified by the DOL, an AHP would be authorized to
operate nationwide, exempt from state insurance laws. State
coverage requirements such as well-baby care, preventive services and

40. The states would continue to regulate health insurance sold through traditional
small group markets.
41. Any arrangement that is a “multiple employer welfare arrangement” may have
obligations under ERISA.
42. For more details, see California AHP Report.
43. Id.
Time to Reevaluate Regulation of Self-insured Multiple Employer Arrangements?”
mammograms — would not apply to AHP policies. In the area of rating, an AHP would have the flexibility to set premiums not subject to state rating laws. Each employer group within an AHP could have premiums based on its own claims. The bill has conflicting provisions relating to an employer member’s access to the association’s health coverage. Also, enrolled businesses would not be guaranteed renewal of their coverage; instead, an AHP could offer an employer different coverage at renewal.

The effects of adverse selection from AHPs could impact state-regulated products. Through broad preemption of state guaranteed-issue, rating, marketing, product design and guaranteed-renewability requirements, H.R. 525 would allow AHPs and their insurers to target healthy employers and avoid covering businesses once their employees develop medical needs. This could lead to market segmentation, with healthy people leaving the state-regulated market for AHP coverage and sick people leaving AHPs for state-regulated coverage. Several studies have concluded that premiums for state-regulated policies would increase as a result. For example, the Congressional Budget Office (CBO) estimated that a similar bill would cause approximately 10,000 people to lose coverage because of higher premiums caused by the bill in the state-regulated market. The CBO also estimated a 13% drop in price for AHP coverage, with a cost savings from exemptions from state mandates and covering groups with lower medical costs. Several studies have concluded that the overall effect on the uninsured problem would be minimal (the CBO estimated 550,000 people would be newly covered).

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45. The state where an AHP is located may prohibit policies from excluding certain diseases. Such prohibitions would apply to AHP coverage. The federal standard for hospital stays for childbirth, mental health parity and reconstructive surgery would apply to AHP coverage.

46. See California AHP Report.

47. For a discussion of studies looking at the potential impact of AHPs, see California AHP Report.

In addition, federalizing the regulation of AHPs could increase fraud and abuse.\textsuperscript{49} There has been a long history of insolvency and fraud among association health plans. For example, between 2001 and 2003, four self-insured associations left 66,000 people with more than $48 million in unpaid medical bills that should have been paid by the AHPs.\textsuperscript{50} Although coverage would be less expensive as a result of lower reserve requirements, participating businesses would be exposed to a higher risk of AHP insolvency. Also, in the recent past, the most prevalent way to sell phony health insurance has been through associations. According to the U.S. Government Accountability Office (GAO), between 2000 and 2002, phony health plans left more than 200,000 policyholders with more than $252 million in unpaid medical bills.\textsuperscript{51} Because H.R. 525 would not give the DOL new regulatory staffing resources or the type of authority that state insurance regulators currently have and use – including cease and desist authority that allows quick administrative action without going to court – to find and quickly shut down phony health plans, the bill could lead to increased health insurance fraud.\textsuperscript{52}

**Health Care Choice Act of 2005 (H.R. 2355)**

The “Health Care Choice Act of 2005” (H.R. 2355) would apply to coverage sold in the individual market. It would allow health insurers licensed in one state to do business in other states without complying with other states’ insurance laws.

The legislation seeks to make health insurance more affordable by eliminating the need for insurers to comply with laws in 51 jurisdictions. It also seeks to give consumers more choices of products and companies in the individual market.

Under the bill, a company could choose a “primary” state among those states with solvency standards, called “risk-based capital” (RBC), for health


\textsuperscript{50} Self-Insured Arrangements Report, p. 21.


\textsuperscript{52} AHPs Fraud Report.
insurance issuers. Once licensed in its primary state, a health insurer would be allowed to do business in all other states (called “secondary” states) without meeting solvency and licensing requirements of the states in which it does business. An insurer would not be required to do business in the primary state. All other secondary state standards would be preempted, including guaranteed-issue requirements, benefit mandates, rating laws, standards for reviewing denied claims (external appeals) and rules governing marketing practices. This would be a significant departure from current law. Insurers today must be licensed in and comply with the laws of every state where they conduct insurance business.

H.R. 2355 would also restrict the general authority of insurance regulators in primary and secondary states in the following areas: Solvency regulation and oversight activities, fraud and abuse, and payment of claims (limiting the use of state unfair claims settlement laws). Under current law, a state may examine an insurer’s financial condition. This bill would change that by allowing a secondary state to conduct financial exams only if the primary state has not conducted one in the recommended time period, and only if the exam is coordinated with other states to avoid multiple exams. Such restrictions on the secondary states’ authority could raise the risk of insolvency.

H.R. 2355 would also limit state authority in the area of fraud and abuse by narrowly defining what constitutes fraud and abuse, and by restricting states’ administrative authority. Under the bill, the secondary

53. While all states have adopted RBC for life and health insurers, only 21 states have adopted RBC requirements for HMOs and other managed care plans. These states include Arizona, Arkansas, Colorado, Connecticut, Georgia, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Nebraska, New Hampshire, North Carolina, North Dakota, Pennsylvania, Rhode Island, Texas, Utah, Virginia and Washington. See NAIC Model Regulation Service, July 2002. The primary state must also have external review unless an insurer provides such review. An insurer’s review must be “functionally equivalent” to the NAIC Health Carrier External Review Model Act. See H.R. 2355 Bill Sec. 4, adding new section 2797 to the Public Health Service Act (PHSA).

54. See H.R. 2355 Bill Sec. 4, adding new section 2796 to PHSA.

55. See definition of “covered laws” in H.R. 2355 Bill Sec. 4, adding new section 2795(7) to PHSA. See also new section 2796. The bill does not require companies to file copies of the policies they intend to sell. A company must provide a “summary” and self-certify that the coverage complies with the primary state’s requirements. H.R. 2355 Bill Sec. 4, adding new section 2796(g) to PHSA. The bill seems to prohibit a state from asking for a copy of the full policy. This is a departure from current regulation, reviewing policies and rates to identify problems before they occur. The bill would also set standards for rates at renewal. H.R. 2355 Bill Sec. 4, adding new section 2796(d) to PHSA. It is unclear whether rating standards in the primary state would apply (it appears likely that the bill would preempt rating standards in the primary and secondary states based on this new federal standard). The bill would also allow insurers to increase rates retroactively. H.R. 2355 Bill Sec. 4, adding new section 2796(d) to PHSA.

56. See H.R. 2355 Bill Sec. 4, adding new section 2795 (6), (9), (10) and section 2796 to PHSA.

57. See H.R. 2355 Bill Sec. 4, adding new section 2796(b)(1)(C), (D) and (E) and 2795 to PHSA.
states would be required to go to court in a fraud case, whereas now, states
can shut down a phony insurance company through an administrative
process — a much quicker way to prevent an illegal entity from spreading. 58

There is also concern that H.R. 2355 would create asymmetry in the
health insurance markets in most states, causing a high degree of market
destabilization. In New York, for example, health insurers are required to
sell policies on a guaranteed-issue basis, cover standardized benefits and set
premiums using community rating. These rules would not apply to
companies licensed in a different primary state that has different rules;
therefore, insurers licensed under New York’s laws would be at a
significant competitive disadvantage. Healthy people could self-select less
expensive out-of-state coverage; without a guaranteed-issue requirement,
out-of-state insurers would not have to sell coverage to sick people. New
York companies could not remain in business by covering only sick people.
Consequently, this could adversely impact New York’s consumers who
need comprehensive, guaranteed health insurance, leaving such people with
fewer choices or no options at all.

Provisions in the Health Care Choice Act also raise constitutional and
practical questions about enforcement. H.R. 2355 seeks to give state
insurance departments authority to enforce the new federal standards.
However, under the U.S. Constitution, Congressional authority over state
insurance departments is limited, meaning Congress cannot require states to
do what H.R. 2355 sets out. 59 Unless the legislature in the primary state
enacts a law to adopt these federal standards and to expand the authority of
its insurance department to enforce these laws extraterritorially, consumers
living in secondary states will not be protected by the primary state’s laws.
The bill would prohibit secondary states from enforcing their own laws and,
because of jurisdictional constraints under state constitutions, generally
states are not authorized to enforce the laws of other states. 60

As a practical matter, even if a primary state were to pass a law
extending its regulatory authority to insurance sold in secondary states (the
authority of states to do this may have to be litigated), a primary state’s
resources would be stretched. For example, consumers in California
(population 36 million) who bought a policy licensed in Delaware
(population 840,000) would not be protected by California law. Instead,

58. See H.R. 2355 Bill Sec. 4, adding new section 2796 (b)(1)(G) and section
2795(10) to PHSA. For a discussion of how states investigate and shut down phony
arrangements, see Health Insurance Scams Report. See also Kofman, Mila, Kevin Lucia,
Responding and What Further Steps Are Necessary,” Commonwealth Fund, available at
www.cmwf.org.

59. U.S. Const. amend. X and XI. For a discussion of federalism, see Thomas,
Kenneth, “Federalism, State Sovereignty and the Constitution: Basis and Limits of

60. Another question for the courts is whether Congress could delegate authority to
the legislature of one state to prescribe and enforce the law(s) to be applied in another
state.
California consumers with insurance problems would have to seek assistance from a regulator some 3,000 miles away and staffed to regulate insurance markets on a much smaller population scale.

In addition, H.R. 2355 could also impact employer-sponsored health insurance if cheaper out-of-state policies attract healthy people currently in job-based coverage. The CBO estimates that 1 million people would lose job-based coverage as a result of H.R. 2355 as healthy people leave job-based coverage, causing prices to increase for sicker and older workers and forcing some employers to drop coverage altogether. In addition, the CBO estimates that Medicaid spending would increase by $1 billion (2007-2015) in part as a result of lost job-based coverage among low-wage workers prompted by H.R. 2355.

Health Insurance Marketplace Modernization and Affordability Act of 2005 (S. 1955)

The “Health Insurance Marketplace Modernization and Affordability Act of 2005” was introduced in the U.S. Senate in fall 2005; a revised version was considered and voted out of the Senate HELP Committee in March 2006 (S. 1955). The bill’s sponsors cited a need to “modernize the health insurance marketplace” in order to expand health care access and to reduce costs. Similar to H.R. 525, S. 1955 seeks to help small businesses afford coverage by allowing them to band together through associations. It also seeks to offer more choices of products by allowing insurers to design products that are not subject to state-mandated benefit laws and by establishing a national standard for premium rates for small businesses. The bill also seeks to make health insurance more affordable by trying to streamline how insurance companies are regulated.

Federal Regulation of Association Health Plans S. 1955 would establish federal certification for fully insured association health plans, called “small business health plans” (SBHPs) and exempt these plans from state regulation. Standards for SBHPs are almost identical to those for association health plans in H.R. 525, with a few key exceptions. Self-insured SBHPs are not authorized under S. 1955.

Also, different from H.R. 525, S. 1955 includes deeming provisions. If the DOL does not act on an application within 90 days, an SBHP would be deemed federally certified. Because the bill provides no additional administrative resources to the DOL, it is difficult to assess the thoroughness of review to which SBHP certification applications might be

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62. Id., p. 6.
64. S.1955 Bill Title I Sec. 101, adding new Part 8 to ERISA Title I.
65. S.1955 Bill Title I Sec. 101, adding new Part 8 Sec. 802(d) to ERISA Title I.
subject. The bill would preempt the states’ ability to close down SBHPs. No exceptions e.g., for suspected fraud are provided under the bill.

One concern is that this bill would increase the potential for fraud. For instance, unscrupulous individuals may falsely claim to have real insurance, selling it through phony associations they create, and taking advantage of unsuspecting small businesses and people who enroll in association coverage, in the same way some have done in the recent past, defrauding employers and leaving their employees unprotected — and uninsured. Once deemed federally certified, states would be prohibited from taking action against these bad actors. By the time the federal government investigates, it would be too late, as these types of scams proliferate quickly.66

Similar to H.R. 525, coverage sold through SBHPs would be exempt from state insurance standards like benefit mandates. Generally, SBHPs would be allowed to offer mandate-free policies. Insurers selling through SBHPs would be regulated by the states for solvency.

Similar to H.R. 525, each association would have its own premium rate based on the claims experience of the association group, and that base rate could vary for specific member employers of the association to reflect the claims of each employer group.67 However, S. 1955 would limit this variation to no more than 2:1; that is, premiums for sick groups could be 200% of those for healthy groups participating in the SBHP.68 The legislation would allow insurers to further vary rates without limits for each enrolled small business based on other factors like group size, age, gender, geography, family composition and wellness.69 An SBHP’s claims experience would not be linked to the rest of the small group market.

Similar to H.R. 525, a concern with S. 1955 is that it would further fragment the small group market by exempting SBHPs from state standards that seek to prevent market segmentation — including marketing practices, coverage design, rating and renewability — and by allowing SBHPs to have rates that are not linked to the rest of the small group market. If insurers are successful in attracting healthy groups to buy coverage through SBHPs, premiums for coverage outside the SBHP will be much higher, as healthy groups will stop buying such coverage.

**Federal Standards for All Health Insurance** S. 1955 would establish a new optional national standard that insurers could choose to

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66. A challenge by a state or later removal of certification by the DOL would not help people who became victims during the entity’s operation. Fraudulent operations spread quickly. Employers Mutual LLC, an illegal entity, collected more than $15 million in premiums in just 10 months. See Health Insurance Scams Report.

67. A separate class of business will adversely impact the rest of the market. By their very nature, associations can attract healthy members (e.g., aerobics instructors). Through marketing, benefit design and rating, associations and their insurers can “cherry-pick” healthy businesses out of the market, leaving sicker ones in the small group market. This will make coverage more expensive in the small group market.

68. S.1955 Bill Title I Sec. 101, adding new Part 8 Sec. 805(a)(2)(B) to ERISA Title I.

69. *Id.*
follow. Under the new standard, state benefit laws would no longer apply to individual, small group and large group health insurance. State rating laws in the small group market would also be preempted. The bill would preclude higher and different state laws when insurers choose to operate under the national standard, establishing a ceiling of protections. The bill would also restrict state oversight of health insurance policies and companies.

With respect to mandated benefits, S. 1955 allows health insurers to sell policies exempt from all state benefit mandates in the individual, small group and large group market as long as the insurer also offers a policy with benefits and services covered under any plan option offered to state employees in one of the five largest states (Texas, California, New York, Florida and Illinois). For example, an insurer might choose a high-deductible policy, similar to one option offered to Florida state government employees with an annual deductible of $2,500 for family coverage, leaving employers and individuals in all states a choice of a mandate-free policy or a high-deductible one.

In addition to fewer choices, this could invite adverse selection, thereby raising prices for comprehensive coverage. S. 1955 would allow self-selection, sorting people with serious illness into the relatively more comprehensive plans, and raising the cost of such coverage substantially compared to mandate-free policies. Over time, it would be difficult for insurers to continue to offer comprehensive policies if only people with medical needs bought them. Consequently, comprehensive coverage could disappear from the market.

With respect to rating, S. 1955 would establish an optional national standard for small group premiums, which insurers may choose to follow. The new federal standard is based on the old NAIC model act. S. 1955 would allow insurers to charge a small business with sick workers twice as much as a business with healthy workers when first purchasing a policy. The bill would restrict surcharges based on an employer’s industry to 15% (on top of the base rate). Additional premium variation without limits could be applied based on other factors, including age, gender, geography, family composition, wellness programs and small business group size. Different from the NAIC model, however, the bill excludes coverage sold through SBHPs and is unclear whether other associations would be allowed their own price not tied to the rest of the market (called “class of business” in the

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70. S. 1955 Bill Title II Sec. 201, adding new section 2922 to PHSA.
72. For a discussion of adverse selection, see Claxton Report, p. 4. This problem is also discussed in an industry letter on S. 1955. See Ignani, Karen, president and CEO, America’s Health Insurance Plans, letter to Sen. Michael Enzi, March 7, 2006 (copy available from authors).
73. S. 1955 Bill Title II Sec. 201, adding new section 2911 (b) to PHSA.
Under the old NAIC model, price differences were 26 to 1 for the same coverage; however, S.1955 could create greater variations between coverage sold through associations and in the small group market.75

At renewal, insurers would be allowed to increase a small employer’s premium by up to 15% based on the claims of its employees and their dependents. The 15% increase for a specific group would be in addition to whatever renewal increase was applied to all policyholders.76

The bill would preempt existing state rate standards. Although there are 37 states with rate bands, only four follow the old NAIC model act’s restrictions on health-based rating and industry. None of the four, however, allow the type of class structure contemplated in the bill — that is, associations having their own class not tied to prices for the small group market. The 12 states that follow the current NAIC model act that provides for adjusted community rating would be preempted also. In these 12 states, the impact would be most dramatic, as insurers would be able to raise prices significantly for sicker workers and older people. Only two jurisdictions have not enacted any small group rate reforms: Hawaii and the District of Columbia. Because the rating standards in the bill are optional, insurers in those two jurisdictions would not have to comply with new national rating standards.

Other: Regulation of Insurance Companies S. 1955 would establish other new regulatory national standards and would limit the authority of the states in overseeing how insurance companies operate. A private board of insurance industry representatives and state officials would develop national standards in four areas: rate and form filings, market conduct exams, internal claim denial appeals and prompt payment of claims requirements. These would replace current state standards.

S. 1955 provides specific guidelines for the private board to follow. For example, new national rate and form filing requirements would allow for self-certification by insurers. Market conduct examinations would be restricted and fines would be limited for certain violations.77

This oversight approach is different than the one states use now. Currently, by scrutinizing policies and rates — in other words, not allowing

74. Some regulators believe that rate restrictions in the small group market would be undermined if insurers are allowed to separate their association business from the rest of the small group market.
76. S. 1955 Bill Title II Sec. 201, adding new section 2911 (b) to PHSA.
77. S. 1955 Bill Title III Sec. 301, adding new section 2931, et al., to PHSA. Some regulators raise the additional concern that “market harmonization” requires states to write into state law procedural rights for insurers that would result in decreased consumer protection. They argue that “no federal financial regulator is subject to, or grants, these types of rights to the industry they regulate.” Gomez, Jorge, 2006. Insurance commissioner, Wisconsin Insurance Department, letter to Sen. Michael Enzi, March 14 (copy available from authors).
self-certification — many state insurance regulators identify and prevent problems before they occur. Likewise, broad state authority over market conduct has enabled the states to detect problems and require corrective action. Limiting oversight authority could have significant adverse implications for insurance consumers.

**Enforcement of New Federal Standards for Individual and Group Health Insurance**

HHS would have the authority to issue regulations providing guidance and the federal courts would have the exclusive right to interpret the standards for individual and group health insurance under S. 1955. However, the bill would not authorize the federal government to enforce, nor would it authorize injured consumers to go to federal court to enforce, these national standards. For enforcement, S. 1955 looks to the states.

Constitutional limitations prevent Congress from requiring the states to enact the national standards. Therefore, S. 1955 would give states an option of doing so. However, effective enforcement may be difficult. In particular, if a state were to enact the new standards, an insurer could challenge a state’s interpretation in federal court. Some state officials have argued that this could have a chilling effect on state enforcement if a state is sued, and thereby forced to litigate its enforcement actions in federal court.

S. 1955 is self-implementing. If a state chooses not to adopt the national standards, S. 1955 would authorize insurers to offer policies under the new national standards. If a state were to apply its old laws or prohibit an insurer from selling national coverage, S. 1955 would authorize the insurer to sue the state in the federal court of appeals on expedited review.

In summary, the enforcement under S. 1955 represents a new approach to regulating health insurance, with four key departures from current law. The bill:

- Would authorize a regulated industry to sue its primary regulator, a state, in federal court on expedited review (without an initial trial in district court, which is a typical process for lawsuits);
- Would not create a fallback federal agency to enforce national standards if the states choose not to;
- Would authorize insurers to offer insurance products that are not subject to state or federal regulatory oversight; and
- Would not create a federal cause of action for injured consumers to enforce the new federal standards in federal court.

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78. S. 1955 Bill Title II Sec. 201, adding new section 2912(a), 2914(a), 2924, 2932 (authority of HHS) and 2934 to PHSA.
79. S. 1955 Bill Title II Sec. 201, adding new section 2913(b)(3) and (4) to PHSA.
81. S. 1955 Bill Title II Sec. 201, adding new section 2914 to PHSA.
The new regulatory framework would largely rely on self-regulation by insurers and could result in insurance consumers relying on the insurance industry to operate appropriately and to not break the law. However, absent oversight and accountability, S. 1955 would create incentives for insurers to do just the opposite.

**Conclusion**

The Small Business Health Fairness Act of 2005 (H.R. 525), the Health Care Choice Act of 2005 (H.R. 2355) and the Health Insurance Marketplace Modernization and Affordability Act of 2005 (S. 1955) if enacted would fundamentally change the way health insurance is regulated in the United States. In this context, the future of health insurance regulation is not entirely clear.

Congressional sponsors appear to depart from traditional reliance on the states as laboratories for innovation and as primary regulators of health insurance. In the past, federal legislation established a floor of national standards. These three proposals would do the opposite. Also, while in the past Congress heavily relied on the states to implement federal standards, the bills pending in Congress would substantially restrict the states’ ability to regulate health insurance. All three bills would have the effect of reducing the overall level of health insurance regulation by any level of government. While they would restrict the authority of the states to regulate risk selection, to limit unfair market practices and to engage in oversight, none of the proposals would invest substantial new regulatory authority or capacity with the federal government. In this respect, the three bills could be viewed as deregulating health insurance to varying degrees.

The three bills intend to make markets more competitive by making it easier for insurance companies and associations to operate — that is, not having to do business within the constraints of 51 different sets of regulators and rules. An unintended consequence, however, may be to allow new ways to segregate health insurance markets by risk. Consequently, to the extent that current insurance regulations have reached a balance in promoting competition while ensuring an equitable spreading of risk — through rating, covered benefits and other rules that protect access to coverage by healthy and sick alike — the segmented market could destabilize premiums and coverage. Ironically, this may lead to a reduction in protection from medical expenses that health insurance offers individuals, families and employers. It may lead to no private health insurance options for consumers with medical needs and fewer choices for others. It remains to be seen what direction for health insurance regulation the Congress may set, and what changes in private coverage may result.
### State Small Group Standards

<table>
<thead>
<tr>
<th>State</th>
<th>Group Size</th>
<th>Type of Rating Restriction: Small Group Market</th>
<th>Comments/Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>2-50</td>
<td>Rate Bands Allowed: health (+/-25%), age (4:1), group size (+/-15%), gender, family composition, geography Prohibited: industry Renewal: same (1/12 months increase)</td>
<td></td>
</tr>
<tr>
<td>AK</td>
<td>2-50</td>
<td>Rate Bands Allowed: health (+/-35%), industry (15%) Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>AZ</td>
<td>2-50</td>
<td>Rate Bands Allowed: health (60%) Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
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<tr>
<td>AR</td>
<td>2-50</td>
<td>Rate Bands Allowed: health (+/-25% per class) Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>CA</td>
<td>2-50</td>
<td>Rate Bands Allowed: health (+/-10%), age, geography, and family composition Renewal same</td>
<td></td>
</tr>
<tr>
<td>CO</td>
<td>1-50</td>
<td>Rate Bands Allowed: health (+ 10%/-25% including industry), smoking (15%) Prohibited: gender and group size Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>CT</td>
<td>1-50</td>
<td>Adjusted Community Rating Allowed: group size (1.25 : 1), industry (15%), gender, age and geography (defined) Renewal: same</td>
<td></td>
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<tr>
<td>DE</td>
<td>1-50</td>
<td>Rate Bands Allowed: health (+/-35% per class), gender and geography, industry (15%) Prohibited: group size Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
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<tr>
<td>DC</td>
<td>2-50</td>
<td>No rating restrictions</td>
<td></td>
</tr>
<tr>
<td>FL</td>
<td>1-50</td>
<td>Rate Bands Allowed: health (+/-15%), geography and family composition defined Prohibited: industry Renewal: trend plus 10% for claims, health &amp; duration (1/12months)</td>
<td></td>
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<tr>
<td>GA</td>
<td>2-50</td>
<td>Rate Bands Allowed: health (+/-25%), group size (+/-15%), age, gender, industry, geography Renewal: trend plus 15% (1/12 months)</td>
<td></td>
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<tr>
<td>State</td>
<td>Group Size</td>
<td>Type of Rating Restriction: Small Group Market</td>
<td>Comments/Exceptions</td>
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<tr>
<td>HI</td>
<td>2-50</td>
<td>No rating restrictions</td>
<td>Largest plans may voluntarily community rate</td>
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<tr>
<td>ID</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-50% per class), age defined</td>
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<td></td>
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<td>Renewal: trend plus 15% for claims, health &amp; duration</td>
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<td>IL</td>
<td>2-50</td>
<td>Rate Bands</td>
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<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class)</td>
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<td>Renewal: trend plus 15% for claims, health &amp; duration</td>
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<td>IN</td>
<td>2-50</td>
<td>Rate Bands</td>
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<tr>
<td></td>
<td></td>
<td>Health +/−35%</td>
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<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp; duration</td>
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<tr>
<td>IA</td>
<td>2-50</td>
<td>Rate Bands</td>
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<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class), group size (1.2), age, gender (must be a blended rate) Prohibited: industry</td>
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<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp; duration</td>
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<tr>
<td>KS</td>
<td>2-50</td>
<td>Rate Bands</td>
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<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class), industry (15%) Renewal: trend plus 15% for claims, health &amp; duration</td>
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<tr>
<td>KY</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-50% per class), age (5:1), gender, industry, geography Renewal: trend plus 20% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>LA</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Rate bands for (3-35). No restrictions for groups of 2 or 36-50.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-33% per class) Renewal: trend plus 20% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>ME</td>
<td>1-50</td>
<td>Adjusted Community Rating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: 1:5 band for age, geography &amp; industry; additional adjustment for family composition, smoking, wellness programs, and group size Prohibited: gender, health status and claims experience Renewal: same</td>
<td></td>
</tr>
<tr>
<td>MD</td>
<td>2-50</td>
<td>Adjusted Community Rating</td>
<td></td>
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<td></td>
<td></td>
<td>Allowed: 40% for age and geography Prohibited: industry, gender, and group size Renewal: same</td>
<td></td>
</tr>
<tr>
<td>MA</td>
<td>1-50</td>
<td>Adjusted Community Rating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: 2:1 bands for: age, size (+/-5%), industry, and participation rate. Geography (+/-20%), up to 5% wellness discount Prohibited: gender Renewal: same</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Group Size</td>
<td>Type of Rating Restriction: Small Group Market</td>
<td>Comments/Exceptions</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>---------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>MI</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Insurers that offer coverage to groups of one may increase premiums by 25%. BCBS: g-issue to sole proprietors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Commercial carriers: Allowed: +/-45% for health, industry, age, group size Adjusted community rating for BC/BS and HMOs Allowed: +/-35% for industry and age (HMOs are also allowed to use group size in this overall band) Renewal: trend plus 15% for changes in case characteristics but must stay within band above**</td>
<td></td>
</tr>
<tr>
<td>MN</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: +/-25% for health, claims, duration and industry; age (+/-50%); 20% b/w geographic areas Prohibited: gender Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>MS</td>
<td>1-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class for health) Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>MO</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Rating restrictions applicable to certain groups (sized 3-25). Otherwise no restrictions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class), industry (10%) Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>MT</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Gender rating is prohibited by human rights laws</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class), industry (15%) Prohibited: gender Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>NE</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class), industry (15%) Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>NV</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-30% per class), industry (20%) Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Group Size</td>
<td>Type of Rating Restriction: Small Group Market</td>
<td>Comments/Exceptions</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>-----------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>NH</td>
<td>1-50</td>
<td>Adjusted Community Rating</td>
<td>REPEALED old adjusted community rating and replaced w/rate bands (+/- 15% for health; 4:1 age, 15% for area, 20% for group size, 20% industry, no gender – these were repealed in 2005 after small groups experienced huge rate hikes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: 3.5:1 for age, groups size, and industry; family composition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibited: health, claims, duration, gender, and geography</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 20% transitional for 2006; afterwards same as at offer</td>
<td></td>
</tr>
<tr>
<td>NJ</td>
<td>2-50</td>
<td>Adjusted Community Rating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: 200% for age, gender, and geography</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibited: health, group size, industry, claims, and duration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal same rules</td>
<td></td>
</tr>
<tr>
<td>NM</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-20% per class); 250% band for: age, gender, geography, industry, and smoking</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibited: group size</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 10% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>NY</td>
<td>2-50</td>
<td>Community Rating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: geography and family composition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibited: health, group size, industry, claims, age, gender, &amp; duration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: same</td>
<td></td>
</tr>
<tr>
<td>NC</td>
<td>1-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: +/-20% for age, gender, family composition, geography, claims experience and administrative costs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>ND</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Rating restrictions apply only to groups sized 2-25.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-20% per class), industry (15%), age (4:1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibited: gender</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>OH</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-35%); industry (+/-15%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
</tr>
<tr>
<td>OK</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class); industry (15%)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp; duration</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>An HMO may fix rates of payment under either a system of community rating, community rating by class, adjusted community rating or under all three systems.</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Group Size</td>
<td>Type of Rating Restriction: Small Group Market</td>
<td>Comments/Exceptions</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>-----------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>OR</td>
<td>2-50</td>
<td>Adjusted Community Rating</td>
<td>Rating restrictions apply only to groups sized 2-25.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: age (43% of average area rate),</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>geography defined</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibited: health, group size, industry,</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>claims, gender, and duration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: same (1/12 months)</td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>2-50</td>
<td>No rating restrictions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Adjusted community rating for BCBS and HMOs</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: +/-15% variation allowed based on all</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>factors</td>
<td></td>
</tr>
<tr>
<td>RI</td>
<td>1-50</td>
<td>Rate Bands</td>
<td>Adjustment for health allowed only for carriers that used health status prior to June 1, 2000.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-10%); age, gender and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>family composition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibited: all other factors (group size and</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>industry)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: same (1/12 months)</td>
<td></td>
</tr>
<tr>
<td>SC</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class), group size</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(20%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>duration</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class), industry</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(15%), age (3:1)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>duration</td>
<td></td>
</tr>
<tr>
<td>TN</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Rating restrictions apply only to groups sized 3-25.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-35% per class), industry</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(15%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>duration</td>
<td></td>
</tr>
<tr>
<td>TX</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-25% per class), industry</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(15%), group size (20%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>duration (1/12 months)</td>
<td></td>
</tr>
<tr>
<td>UT</td>
<td>2-50</td>
<td>Rate Bands</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: health (+/-30% per class), industry</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(15%), group size (20%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal: trend plus 15% for claims, health &amp;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>duration</td>
<td></td>
</tr>
<tr>
<td>VT</td>
<td>1-50</td>
<td>Pure Community Rating</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Allowed: family composition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prohibited: health, group size, industry,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>claims, age, gender, geography and duration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renewal same</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Group Size</td>
<td>Type of Rating Restriction: Small Group Market</td>
<td>Comments/Exceptions</td>
</tr>
<tr>
<td>-------</td>
<td>------------</td>
<td>-----------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>VA</td>
<td>2-50</td>
<td>No rating restrictions</td>
<td>Standard and essential products: Health +/-20%; industry and group size prohibited; Renewal same as initial</td>
</tr>
<tr>
<td>WA</td>
<td>2-50</td>
<td>Adjusted Community Rating</td>
<td>Allowed: age (375%), wellness, family composition, and geography Prohibited: health, claims, duration, gender, group size, and industry Renewal: same (may adjust by +/-4%; greater variations subject to approval of commissioner). Increase 1/12 months</td>
</tr>
<tr>
<td>WV</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Allowed: health (+/-30% per class), industry (15%) Renewal: trend plus 15% for claims, health &amp; duration</td>
</tr>
<tr>
<td>WI</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Allowed: health (+/-30% per class) Renewal: trend plus 15% for claims, health &amp; duration</td>
</tr>
<tr>
<td>WY</td>
<td>2-50</td>
<td>Rate Bands</td>
<td>Allowed: health (+/-35% per class), industry (15%) Renewal: trend plus 15% for claims, health &amp; duration</td>
</tr>
</tbody>
</table>

Source: Georgetown University Health Policy Institute 2006

Notes: The terms “adjusted community rating” and “community rating” mean that insurers are prohibited from adjusting rates for each employer group based on the group’s claims or other health-factors. Some state laws refer to “adjusted community rating” but allow adjustments based on claims and/or health. This chart calls these laws “rate bands.” Also, unless otherwise indicated in the chart, states with rate bands allow adjustments that are actuarially sound for age, gender, industry, geography and group size. Adjusted community rating generally prohibits these unless otherwise noted in the chart.
Attachment B

**Washington State Premiums for Selected Individual Products by Product Type and Subscriber Age, 1998**

<table>
<thead>
<tr>
<th>Product</th>
<th>Age 25</th>
<th>Age 45</th>
<th>Age 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Comprehensive</td>
<td>$174</td>
<td>$222</td>
<td>$390</td>
</tr>
<tr>
<td>Blue Cross (excludes maternity, mental health)</td>
<td>$ 89</td>
<td>$159</td>
<td>$296</td>
</tr>
<tr>
<td>Difference</td>
<td>2:1</td>
<td>1.4:1</td>
<td>1.3:1</td>
</tr>
</tbody>
</table>

Significant Insurance Litigation Post-Hurricane Katrina

Kara D. Binderup, J.D.*

Introduction

This article is not intended to identify every action filed against insurers as a result of the 2005 hurricane season, but rather to describe noteworthy theories of recovery and preliminary rulings in such actions. Likewise, only certain related legislative and regulatory action is described herein.

Cases Filed — Theories of Recovery


This class action seeks a declaration by the 19th Judicial District Court that water entered in the city of New Orleans August 29, 2005, due to breaches in certain floodwalls. The plaintiffs assert the resulting damage to their homes was caused by acts of negligence and windstorm, standard covered perils in homeowners insurance policies, rather than the excluded perils of “rising water” and “acts of God.” The class action also seeks an order of mandamus directing the Louisiana insurance commissioner to interpret homeowners insurance policies in accordance with such a declaratory judgment. The circumstances surrounding the breached levees in New Orleans make this theory of recovery exclusive to Louisiana plaintiffs.

* Staff Attorney I, National Association of Insurance Commissioners.
Scruggs Claims

These cases are among many filed by plaintiff’s attorney Richard Scruggs on behalf of Mississippi homeowners. News reports estimate the number of Scruggs’ Hurricane Katrina clients at nearly 3,000. Although not a class action, the individual claims make similar allegations of misrepresentation and ambiguous policy language. The plaintiffs allege that their homes were destroyed by Hurricane Katrina, and that their insurance companies denied coverage based on exclusions for damage caused by water or storm surge.

Plaintiffs in the following cases are represented by Scruggs:

- **Tuepker v. State Farm Fire & Cas. Co.**, No. 05-559 filed Nov. 21, 2005, United States District Court for the Southern District Mississippi, Southern Division. Complaint alleges agent included hurricane endorsement in the policy and expressly represented that the plaintiffs would have full and comprehensive coverage in the event of hurricane damage. Plaintiffs claim the exclusions contradict the language of the policy and the public policy of Mississippi.

- **Stanley v. Metro. Prop. & Cas. Ins. Co.**, No. 05-550 filed Nov. 17, 2005, United States District Court for the Southern District Mississippi, Southern Division. Complaint alleges that agent represented policy would provide full and comprehensive coverage for hurricane damage. Plaintiffs claim exclusions contradict statutory law of Mississippi.

- **Buente v. Allstate Prop. & Cas. Ins. Co.**, No. 05-712 filed Nov. 30, 2005, United States District Court for the Southern District Mississippi, Southern Division. Complaint alleges that agent told them they did not need optional flood insurance because they were not in a flood plain and that the policy would cover any hurricane damage. Plaintiffs claim the exclusions contradict representations made in procuring the insurance and language of the policy.

- **Leonard v. Nationwide Mut. Ins. Co.**, No. 05-2021 filed Oct. 5, 2005, Chancery Court of Jackson County, Mississippi. Complaint alleges that policy included hurricane deductible, agent represented they did not need additional flood insurance and defendant insurer represented full and comprehensive coverage.

Judicial interpretations of the water and storm surge exclusions have begun in response to motions to dismiss. Preliminary decisions in **Tuepker** and **Buente** are described later in this article.
Significant Insurance Litigation Post-Hurricane Katrina


On behalf of the people of the state of Mississippi, Attorney General Jim Hood complains that property owners purchased defendants’ policies for the primary purpose of insuring against any and all hurricane damage. Hood alleges that exclusions for property loss caused by water, whether or not driven by wind, violate public policy. Specifically, Hood claims that the exclusions seek to deny coverage even where a covered peril contributes to the damage, if it is in concert with an excluded peril. The complaint alleges that defendants are circumventing a proximate cause analysis, violating both Mississippi precedent and common law.

The complaint also alleges that defendants’ policies are unconscionable adhesion contracts, the policy exclusions are ambiguous on their face and that defendants’ actions violate §75-24-5(1) of the Mississippi Consumer Protection Act. Finally, Hood alleges that defendants are coercing policyholders into accepting reduced payments on claims in exchange for releasing their insurance companies from further liability.

Valued Policy Cases

A valued policy is frequently at issue when insuring against fire. Such policies place a value on a property in the event of total loss. Valued policy statutes generally mandate that insurers who have placed a value on the property will be liable to the homeowner for that amount if the home cannot be salvaged.

Similar to a proximate causation analysis, a valued policy approach seeks to compensate homeowners for damage caused in part by a covered peril. However, successful plaintiffs in a valued policy case may fare even better than those who prevail with proximate causation. A recent Florida decision held that, when a policyholder suffers a total loss, the policy must pay its face amount even if the covered peril did not cause the entire loss. See Mierzwa v. Florida Windstorm Underwriting Association, 877 So.2d 774 (2004).

The Mierzwa case interpreted Florida’s Valued Policy Law, F.S.A. §627.702, which was later amended to avoid a repeat of the Mierzwa case. It now provides that the intent of the statute is not “to require an insurer to pay for a loss caused by a peril other than the covered peril.” Nevertheless, the Mierzwa decision provides a possible basis for recovery to Katrina victims with valued policies. Two class actions have been filed based on Louisiana’s Valued Policy Law, LSA-R.S. §22:695. The Louisiana statute resembles Florida’s, pre-amendment, in that it does not state whether the damage in question was caused by a covered or uncovered peril.
The valued policy class actions are:


**Miscellaneous Cases**

Post-Hurricane Katrina litigation has brought a number of unusual claims, with named defendants including President George W. Bush, the U.S. Army Corps of Engineers and the corporate owner of a runaway barge. Noteworthy cases involving insurance include Comer v. Nationwide Mutual Insurance Co., No. 05-436 (S.D. Miss. filed September 20, 2005). In this class action, plaintiffs allege unconscionable and ambiguous exclusions, as well as violation of consumer protection laws by defendant insurance companies. However, the complaint also names various oil and chemical companies as defendants, alleging the development of their products led to global warming, creating in Katrina “a storm of unprecedented strength and destruction.”

Another novel class action is Craddock, Sr. v. Safeco Insurance Co., No. 2005-14157 (22nd Jud. Dist. Ct. La. filed September 23, 2005). The complaint alleges that similarly situated homeowners suffered loss of trees as a result of Hurricane Katrina. Plaintiffs claim that “loss of trees” is a covered peril; however, defendant insurance companies classified these losses as “debris” and issued nominal amounts under homeowners’ policies. The action seeks a declaratory judgment and damages.

**Rulings and Judgments**

As of the time of this publication, several actions have seen preliminary rulings. U.S. District Court Judge Louis Guirola, who would have heard Hurricane Katrina cases filed in the Southern District of Mississippi, recused himself from such actions after filing suit against Nationwide Mutual Insurance Company for denying his own Hurricane Katrina claim. Guirola is represented by Scruggs.

Consequently, Judge L.T. Senter of the Southern District has been the only judge to issue Mississippi rulings to date. Judge Senter denied the defendant’s motion to dismiss in Buente, No. 05-712, 2006 WL 763085 (S.D. Miss. March 24, 2006) (clients of Scruggs). The court ruled that Allstate’s “storm surge” exclusion is ambiguous when read with the “Hurricane Deductible Endorsement” included in the Buentes’ policy. The “storm surge” provision seeks to exclude any combination of covered and uncovered losses, but the court finds the causation issue to be fact-specific for trial. The court conducted a similar analysis in denying defendant State Farm’s motion to dismiss in Tuepker, No. 05-559, 2006 WL 1442489 (S.D. Miss. May 24, 2006) (also clients of Scruggs).
Judge Senter denied the plaintiffs’ motion for partial summary judgment in Buente, No. 05-712, 2006 WL 980784 (S.D. Miss. April 12, 2006). In examining the “flood exclusion” provision of the policy, the court found the exclusion to be clear and unambiguous.

A notable trend in preliminary motions for Katrina cases has been the grant of remand from federal to state courts. In the following cases, defendants had removed to federal court and subsequently failed to establish improper or fraudulent joinder of local defendants:


- Radlauer v. Great N. Ins. Co., No. 06-1737, 2006 WL 1560791 (E.D. La. May 16, 2006). Court granted remand to state court, rejecting defendant’s argument that claims against non-diverse defendant were not sufficiently related to claims against diverse defendants.

- King v. Allstate Indem. Co., No. 05-675, 2006 WL 1139932 (S.D. Miss. April 25, 2006). Court granted remand to state court, rejecting defendant’s argument of fraudulent joinder in that plaintiff had no viable theory upon which to proceed against non-diverse defendant.

- Schwartz, Jr. v. Chubb & Sons, Inc., No. 05-6885, 2006 WL 980673 (E.D. La. April 11, 2006). Court granted remand to state court, rejecting defendants’ argument that non-diverse defendant was improperly joined. Defendants argued improper joinder on two bases: inability to prove a set of facts that would entitle plaintiffs to relief against non-diverse defendant; and failure to state claims sufficiently related to those against diverse defendant.


Although the Katrina plaintiffs prevailed in these motions to remand to state court, those who asked for attorneys’ fees resulting from removal and remand (Radlauer and Schwartz) were denied.
Other preliminary rulings direct Katrina plaintiffs to amend their complaints. In Arias-Benn v. State Farm Fire & Casualty Insurance Co., No. 05-6269, 2006 WL 1207951 (E.D. La April 26, 2006), the plaintiff asserted individually and on behalf of a class that State Farm failed to reimburse claimants for damages to freezer and/or refrigerator units resulting from loss of electrical power. The court found that the plaintiff had failed to identify a provision of her homeowners policy that was breached by State Farm. The court denied the defendant’s motion to dismiss and gave leave for the plaintiff to amend her complaint to include a more specific allegation of the breach.

In Comer, No. 05-436, 2006 WL 1066645 (S.D. Miss. February 23, 2006), mentioned previously as a “global warming” approach to recovery, the court grappled with the proposed consolidation of four defendant classes: defendant insurance companies; defendant mortgage companies who allegedly failed to require sufficient insurance coverage on their properties; defendant chemical manufacturers for their contribution to global warming; and defendant oil companies, also for contribution to global warming.

The court found that defendant insurance companies and mortgage companies should not be subject to the class action, given that the nature of claims against the defendants were contract actions and each plaintiff is uniquely situated. The court dismissed the action as to those defendant classes. Finding the remaining chemical and oil defendants to be subject to class action tort claims, the court gave leave for plaintiffs to amend their complaint to clarify their claims and make any additions.

### Legislative and Regulatory Action

In the days following Hurricane Katrina, state insurance regulators issued many directives to answer questions from the industry and to aid consumers. Perhaps the most aggressive directive was issued in Bulletin No. 2005-6 by Mississippi Insurance Commissioner George Dale on September 7, 2005. In addressing the wind vs. water issue in loss coverage, Commissioner Dale stated his expectation that “where there is any doubt, that doubt will be resolved in favor of finding coverage on behalf of the insured.” Although many states have common law standards resolving ambiguity in favor of the policyholder, this strongly worded bulletin spoke directly to the flood exclusions that became so controversial, in the media and in the courts, after the storm.

State legislatures have responded to the 2005 hurricane season with a number of insurance-related bills and resolutions. Two bills were passed by the 2006 Louisiana Legislature extending the time period by one year for victims of Hurricaness Katrina and Rita to file claims on their policies and to file lawsuits against insurers, respectively. House Bills 1289 and 1302 have been sent to Louisiana Governor Kathleen Babineaux Blanco as of publication time.
Resolutions have also emerged from the 2006 Louisiana Legislature urging insurers to offer rate reductions for steel-framed houses (HR 134), and urging the U.S. Congress to establish a catastrophic reinsurance fund to support the states in keeping premiums rates affordable (HCR141). Likewise, the 2006 Florida Legislature urged Congress to support a National Catastrophe Insurance Program (HM 541).


Conclusion

The scope of damage caused by the 2005 hurricane season indicates these lawsuits will be moving through the court system for years to come. Even if flood exclusions are uniformly upheld throughout the affected states, the process of establishing whether individual homes were destroyed by wind or water will be lengthy and expensive. Without a doubt, these leading cases will be closely watched as claimants and insurers plan for the future. This publication will periodically update readers with noteworthy developments in hurricane-related insurance litigation.
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Mila Kofman  
Associate Research Professor  
Georgetown University  
3300 Whitehaven Street, NW, Suite 5000  
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