NAMIC®
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES

317.875.5250 | [F] 317.879.8408
3601 Vincennes Road, Indianapolis, Indiana 46268

202.628.1558 | [F] 202.628.1601
20 F Street N.W., Suite 510 | Washington, D.C. 20001

January 20, 2023

Commissioner Karima Woods
D.C. Department of Insurance, Securities & Banking
1050 First Street, NE Suite 801
Washington, DC 20002

Via email

RE: NAMIC Comments—DISB Draft Data Call—Potential for Unintentional Bias in Automobile Insurance

Commissioner Woods,

The National Association of Mutual Insurance Companies (NAMIC) appreciates the opportunity to provide comments of the draft data call related to the potential for unintentional bias in private passenger automobile insurance policies in the District of Columbia.

NAMIC is the largest property and casualty insurance trade association in the country, with more than 1,500 member companies supporting local, regional, and national member companies who write more than two-thirds of the U.S. private passenger auto insurance market and over $750 million direct written premium in the District of Columbia.

NAMIC and our members believe firmly in the fair treatment of all policyholders. Mutual insurance companies are built on the notions of community and inclusivity, and the mutual model has a long and proud history of service to minority communities. NAMIC and our members are adamantly opposed to discrimination based on race and unfair discrimination in general, and we support legislative policies to prevent these practices, many of which are already established in the DC Insurance Code.

NAMIC appreciates DISB's transparent and collaborative approach to this review and respectfully offers the following comments regarding the process in general:

- To begin, NAMIC encourages the department to identify the specific problem it is looking to solve, rather than listing potential harms. A project of this magnitude and significance should be thoroughly vetted to get it right, the first time. Providing specific problems being studied in conjunction with clear definitions and expectations is essential to the long-term success of the project. We remain committed to working in good faith with the Department, and the more clarity and detail can be provided at the outset, the better we expect the Department's experience to be in reviewing submitted data.

- It is nearly impossible to prove the absence of something in any context. In the business of insurance, this approach is antithetical to the rule of law and contrary to regulatory approaches to market regulation. The careful review and ongoing analysis of rating factors used by insurers is not new. In fact, numerous government, industry, and academic studies of the rating and underwriting process have not found evidence of unfair discrimination.

- In addition, NAMIC has significant data privacy concerns with the data call. The proposed data call will generate voluminous amounts of company and policyholder data that will flow from insurers through the department to third-party consultants. This raises extensive privacy concerns and calls for heightened awareness and protection of that data. What legal agreements and protections are in place to ensure the security and confidentiality of the data?

- Finally, while NAMIC welcomes the third-party consultant selected to perform the analysis on behalf of the department and to participate in important conversations about fairness in insurance, we remain concerned with the lack of property/casualty insurance domain knowledge displayed in previous public comments and during stakeholder calls. To that end, NAMIC believes the Department's analysis and work product would greatly benefit from an actuarial peer review prior to publication or distribution. This common practice, especially when there are material elements of judgment and industry-specific knowledge that serve to inform an analysis, could be obtained from organizations such as the American Academy of Actuaries, the Casualty Actuarial Society, or other known data analysis or law firms that have presented on similar issues at the NAIC and in other public forums. A thorough and objective peer review of the study could mitigate some of the concerns raised above and provide an additional layer credibility to any findings.

With regard to specific comments on the December 1 draft data call, NAMIC and our member companies offer the following:

1. Data Elements Proposed for Collection

Preliminary Premium Quotes—Utilizing quotes will likely lead to inconsistencies in the data across insurers and policyholders. There are no existing requirements in the D.C. insurance code for insurers to collect or maintain quote data in a specific or consistent fashion to provide to the department. Further there is no standard definition of an insurance quote, and it is unclear from the draft data call at what point in the quote/application process the department considers something a quote for the purpose of this analysis. What specific statutory or regulatory authority does the Department plan to use to collect quotes and how does the department plan to generalize that data to make it consistent across insurers?

Quotes, which are initiated by an applicant, can be derived from one of several distribution channels (through agents, by phone, online direct through carrier or indirectly from a comparison tool). Each channel may lead to a range of outcomes for the same individual. In addition, there are an assortment of variables and factors that can be used to obtain a quote that could lead to different results for the same individual and the same insurer.

Any study rooted in the analysis of preliminary quotes rather than verified, underwritten, and bound coverage will be of questionable value. Quotes may be based on incomplete or assumed data, change over time, are not necessarily retained consistently across insurers, and may not be what consumers pay for insurance after the complete underwriting process. For example, the quote process is far from uniform, even within an individual company – consumers or their agents often obtain multiple quotes from the same company selecting different coverages, deductibles, etc. as a way to evaluate options and prices. Underwriting often requires more information, that is collected at different intervals throughout the process, that may modify initial quotes depending on consumer responses, as well as validation of data provided before and after the quote. Verification processes and timelines are also not uniform across carriers, introducing additional variability. Additionally, there can be many reasons that a quote process is started but does not result in a bound policy – many of which are beyond the control of the insurer and should not be interpreted as affirmative decisions taken by insurers.

For these reasons, NAMIC continues to oppose a data call for quote data and urges against oversimplifying the analysis of identified data and rating factors by reviewing quote data. The retention of quote data is not required, and any analysis thereof would fail to present an accurate picture of the cost of auto insurance. Quite simply, a project based on quotes is dangerously likely to produce invalid results.

Underwriting decision—Much like quotes, declinations pose significant challenges in contrast to verified, underwritten, and bound coverage. Declinations may occur when a consumer fails to complete an application, fails to provide additional information following a request from a prospective insurer, or fails to meet underwriting criteria established by rating plans filed with and approved by DISB. While we understand the appeal of a simple yes/no decision for purposes of DISB's analysis, we do not believe such an analysis would provide meaningful results or withstand scientific scrutiny for the purpose it is being sought here.

Premium—The study of premiums charged should not be done in a vacuum – any analysis of premiums should also include consideration of loss costs. Solely looking at premium charged in the absence of considering the risk of loss would be an incomplete and misleading approach to any analysis of insurance pricing.

Loss ratio—Loss ratio is a significantly more appropriate basis for analysis than the other three proposed in DISB's request for comments. The analysis of losses and costs is consistent with the traditional legal understanding of unfair discrimination established under D.C. Code § 31-2231.11. There have been several studies conducted that have found no evidence of unfair discrimination by insurers with respect to pricing. That is to say, loss ratios in areas where there is a higher proportion of minority and/or low-income households are similar or even higher than loss ratios in other areas, including a recent analysis performed by Prof. Robert Klein: *Matching Rate to Risk: Analysis of the Availability and Affordability of Private Passenger Automobile Insurance.*[1]

2. Criteria to be Evaluated for Bias

NAMIC believes the elimination of racism improves every aspect of our relationships, institutions, and business communities. We believe that at its very core, insurance underwriting is a system predicated on and sustained by fair and equal treatment, and that a level playing field is achieved

[1] https://www.namic.org/pdf/publicpolicy/210202_naic_study.pdf

through applying equal, objective standards of risk assessment to all consumers, *not* by contemplating an individual's race when assessing risk.

Comments to date from the Department and its consultant have made it clear that DISB intends to conduct the analysis using inference methodology to infer the races of D.C. policyholders. Property and casualty insurers do not collect race data from their policyholders and have no interest in or desire to do so; NAMIC continues to urge the Department to consider and provide written response and guidance to the following questions:

A. How can the data validate the inferences being drawn in this study?
B. Since the department intends to infer consumer race information, will underlying data and inference methodology and any findings be made available for public review, and actuarial peer review?
C. Even using a generally accepted methodology like BIFSG, there will necessarily be an error rate that results in misclassifying a percentage of the population – how does the department intend to address this concern and the limitations it creates?
D. Will insurers have due process to dispute particular findings, and if so, how?
E. DISB uses new terminology not in the existing laws in D.C. and not defined by the DISB, namely the term "bias". How is that term defined, and how will the definition not conflict with the existing statutory terminology of "unfair discrimination" and "unfairly discriminatory rates" that ensure insurers do not treat similarly situated risks differently and do not separate the price from the underlying costs and expenses?
F. How will DISB use loss ratio information for the segmented groups since any analysis of "unfairness" without a loss ratio analysis provides only half the picture and is certain to lead to unfair subsidization of higher risk drivers by lower risk drivers?
G. Will companies subject to the data call receive complete copies of the third-party vendor's tables and methodologies, so as to understand what has been done with their data and so they can run their own analyses? Similarly, will companies have the capacity to opt-out of receiving some data elements, such as the inferred race of policyholders?
H. What financial arrangement exists between the Department and third parties to conduct this study? Will any costs incurred by the department, for the purpose of this study, be passed on to insurers writing in the District of Columbia?
I. Does the Department have specific legal arrangements in place to protect submitted data from use in concert with other jurisdictions, or for studies, books, white papers, or documentaries? Will

such legal arrangements extend to the third-party consultant as to activity the consultant may undertake outside the constraints of the relationship with DISB?

3. Qualitative Questions from ORCAA

The inclusion of the qualitative questions prepared by ORCAA raises additional substantive and legal concerns. The leading questions and requested information appear rooted in the faulty assumption that insurers are either not complying with current law or that they should be held to some standard other than what currently exists in the DC Insurance Code and related regulations. The questions further suffer from the impression that it is individual companies, or individuals at those companies that determine permissibility, when in fact it is the province of the DC City Council and the Department to establish such parameters through proper legal processes. It is also not appropriate for companies to define or contextualize words for the chosen vendor – that is done through statute and to a lesser degree through regulation when specific authority has been delegated. To the extent that companies are engaged in the kind of testing and analysis contemplated by the qualitative inquiries, it is most likely covered by trade secret protections and any substantive answers should be respected as such. The department should consider including a question to identify whether any statutory or regulatory barriers exist that prevent insurers from performing comprehensive bias or unfair discrimination testing. Such a question would help the department understand potential barriers insurance companies face in completing this testing.

Additionally, the request for a "Gap report" obligating carriers to explain to the vendor what records could not be provided sets an extremely broad and concerning precedent of allowing the vendor to truly step into the shoes of the regulator; it is unclear whether this would be permissible under the DC insurance code.

Finally, the potential for "confirmation bias" extends beyond the qualitative questions provided in the draft data call and raises concerns about the use of collected information exclusively to fit a predetermined narrative seeking to find unfair discrimination. In the spirit of transparency, DISB and ORCAA providing a detailed explanation of the methodology in which the data call was developed and the planned analysis to evaluate bias might alleviate significant industry concerns.

Conclusion

While the purposes and intentions of the Department's initiative are laudable, it is important to conclude with some level-setting: The Private Passenger Auto insurance market is driven by the effort to match rate to risk above all else. Matching rate to risk promotes accuracy, which is the essence of insurance fairness – a system in which insurers most accurately price risk and charge a commensurate premium. Policyholders benefit from risk-based pricing as insurers compete for business and ensure that lower-risk policyholders are not unfairly forced to subsidize higher-risk policyholders.

While NAMIC appreciates the department's urgency in continuing to show progress on this project, we strongly encourage the department to pause and allow the appropriate time needed to establish essential definitions, data points, terminology, etc. between the industry and the department's consultant(s). In addition, there remain several unanswered questions and points of clarification needed in order to effectively move this project forward, including the attached list of specific inquiries from our members regarding details of proposed data fields in the draft Excel spreadsheet. Finally, there is simply too much at stake to hastily issue a data call on a topic with such significant implications for the department, the industry, and consumers. We continue to urge caution and respectfully request the Department take all additional time necessary to clarify remaining questions before proceeding on this initiative – we look forward to continued cooperation with you in our mutual efforts to combat illegal unfair discrimination.

Sincerely,

Matthew Overturf
Regional Vice President – Ohio Valley / Mid-Atlantic Region
National Association of Mutual Insurance Companies
c: 937.935.0432 | moverturf@namic.org

ATTACHMENT A – Additional Questions Specific to Draft Data Call Excel Spreadsheet

Overarching Question: Is "N/A" an acceptable response when the answer is either unknown, the data does not exist, or the data is incomplete or unverifiable? Some of the rows requested might not be available from some companies. Some companies might not use all of the listed items. Examples might include years of driving experience (some companies use driver age instead), tier, and coverage lapses associated with the first named insured.

Quotes data Scope and Definition tab Questions and Comments:

- Why/how were these particular rows chosen?
- Name and address are requested – would it suffice for companies to provide the name and address of the first named insured, or is something else requested? In some cases, the named insured is not a human person.
- For DC auto insurance, deductible is not a policy-level characteristic. Deductible is typically specific to comprehensive and collision coverages of one vehicle.
- Is symbol intended to be numeric? Also, we believe some companies use different symbols for several different auto coverages.
- Comprehensive and collision coverages typically do not have a "limit" (but do each have a separate deductible).
- Most companies include multiple vehicles on one policy; some only include one vehicle on each policy.
- This tab recognizes that there can be multiple drivers associated with one vehicle. It requests the DOB/gender/marital status of "the consumer". Years licensed is requested for the "primary applicant". Does this refer to the driver who most affects the premium, or the "rate driver"?
- Loss History and driving record are used differently be different companies and can vary from company to company even within the same insurer group.
- Should rows for "company" and "group" be included?
- The time period is listed as 1-1-2019 through 12-31-2021. Are these data intended to refer to the "policy effective dates"?
- During the quoting process, we could have multiple touchpoints with a PH (i.e., adjusting coverages/deductible) resulting in multiple quotes, whereupon, even if that client binds with us, there could be multiple unbound quotes. These unbound quotes will result in mistaken perceptions, given that customer ultimately binds with us.
- Identifying the quote channel may not accurately be achievable, requiring "derivation"
- What does DISB mean by "collision limit"? Is this a reference to the deductible for collision?

- What does DISB mean by "comp limit"? Is this a reference to the deductible for comp?
- There will be time periods within the data call survey period of quote-related data not legally required to be secured or maintained where the data does not exist. How does DISB want those limitations handled?
- There may be some sought after quote-related data that is not captured in certain quoting tools and processes while it may be accessible in others. How does DISB want those situations handled?
- Is the "lapse in coverage" cell a "yes/no" field?
- It may not be possible to join vehicle coverage to vehicle types/symbols in unaggregated format, an issue for all applicable coverages (BI, PD, MDCL, COMP, COLL). Symbols are applied at the vehicle level across all coverages. E.g., for comp/collision - comp/collision can vary by vehicle and is set at the vehicle level, not at the quote level.

Application data Scope and Definition tab Questions and Comments:

- Why/how were these particular rows chosen?
- Name and address are requested – would it suffice for companies to provide the name and address of the first named insured, or is something else requested? In some cases, the named insured is not a human person.
- For DC auto insurance, deductible is not a policy-level characteristic. Deductible is typically specific to comprehensive and collision coverages of one vehicle.
- Is symbol intended to be numeric? Also, we believe some companies use different symbols for several different auto coverages.
- Comprehensive and collision coverages typically do not have a "limit" (but do each have a separate deductible).
- Most companies include multiple vehicles on one policy; some only include one vehicle on each policy.
- This tab recognizes that there can be multiple drivers associated with one vehicle. It requests the DOB/gender/marital status of "the primary applicant". This term is unclear and is not defined. Does this refer to the driver who most affects the premium, or the "rate driver"?
- Loss History and driving record are used differently be different companies and can vary from company to company even within the same insurer group.
- Should a row for "insurer group" be included?
- The time period is listed as 1-1-2019 through 12-31-2021. Are these data intended to refer to the "policy effective dates"?
- On line 23 for app outcome, optional values are not provided.
- The terms "tier" and "standardized tier" are not used uniformly and are not well-defined.

- "Application"-specific data may not be consistently available as the difference between quotes and applications is fluid and gray. There can be various "levels" or touchpoints during the quoting process, and then there is the process where carriers start to send to underwriting, after which they bind the policy. This underwriting and then binding piece of the process does not fit within this unclear concept of "application."

Loss data scope and definition tab Questions and Comments:

- Is the purpose of the loss data, to be used to develop loss ratios.
- Is the loss data to be provided, only for new policies?
- Are ALAE and ULAE amounts required? Collecting incurred loss and paid loss amounts would be most useful, and sufficient.
- In regard to a loss ratio test: How are loss ratio percentages to be determined? Is the intention to develop a loss ratio for different groups during a 3- or 5-year period? Is the loss ratio intended to be developed from new and renewal policies, or only new policies? We believe that a loss ratio test will only work (and have a chance to be reliable) including renewals and at the industry level, and multiple years will be needed. We believe one reasonable approach would be to collect, from all companies, the earned premium (during 3 or 5 years ending 12-31-2021) and incurred loss and paid loss amounts from each policy, from accidents/claims which occurred during the same years. How will unusual large losses be limited- for example, the loss amount for each vehicle could be limited, perhaps for each year and each coverage?