Life And Health Speculations

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The Life Game?

By Kenneth M. Heck

Critics of the state insurance regulatory system often point to the barely adequate and sometimes inadequate funding provided by state legislatures. Everyone knows that premium taxes are now considered a type of sales tax and most other sources of revenue (company examinations, agents licensing fees, etc.) wind up in the state general fund rather than insurance department budgets. In fact, the typical insurance department budget may bear little or no relation to what revenue the department actually generates.

A secondary problem arises from the inherently countercyclical nature of government. When times aren't good, as in an economic slowdown, taxes and fees of whatever kind collectible by taxing authorities tend to decline. However, the demand for regulatory action increases as insolvencies and near-insolvencies increase and consumer dissatisfaction burgeons. Just at the point when regulators are most needed they can also be under the most intense pressure to downsize their budgets.

Does this mean that federal regulation is the best solution to the budgetary problems of the fifty state insurance departments? Perhaps not. What is really needed is a countercyclical source of revenue to alleviate the shortfalls from traditional sources during periods of recession. Let's take a look into the proverbial crystal ball for a glimpse into the countercyclical future...

The Year Is 1997

The life insurance industry, suffering from the effect of a serious recession, has witnessed an unexpectedly large number of insolvencies, primarily from small and medium-sized companies. Public disenchantment with the industry, fed by highly sensationalized media coverage, has spawned several innovations in traditional life coverage. One of the most popular is known as the "Life Game."

The Life Game, sponsored by state gaming commissions or state insurance departments (on a state or multi-state basis), provides death benefits to players who purchase tickets for monthly coverage. Prices of tickets vary according to the age and sex of the players. A typical pattern for a multi-state region would look like Table 1.

Table 1

Age	Price per Ticket
0-39	$ 3.00
40-44	6.00
45-49	9.00
50-54	15.00
55-59	21.00

60-64	33.00
65 & Up	69.00

For females, a 20% discount applies below age 40 and a 33% dis-count at ages 40 and above. Tickets are sold wherever lottery tickets are also available during the calendar month prior to the month when coverage begins. Fractional tickets can be purchased at the higher age brackets in units of $3.00 each.

The aggregate ticket sales for each month form a consolidated pot of money from which all bene-fits are paid to players dying during the succeeding month of coverage. All deceased players participate in the pot proceeds equally according to the number of tickets or fractions of tickets purchased. However, no one person can collect more than $100,000 or 2/3 of the pot, whichever is less. All funds remaining in the pot because of this payout limitation are claimed by the state. If no one dies during the month, the entire pot is forfeited to the state. Any player dying after buying a ticket but before coverage begins receives' the purchase price as a refund.

All proofs of death must be received within 30, days after the end of the calendar month of coverage. An 800-number is available to the public for death validation purposes. Of course, suicides and homicides aren't covered and Life Game representatives validate all deaths by inspecting death certificates and coroners' reports. No beneficiary designations are involved since proceeds are paid directly to the estate of the deceased. All players must be permanent residents of the state (or multi-state region) and possess a driver's license or other acceptable form of identification.

A 6% sales tax is deducted from pot proceeds in advance to provide for administration of the Game. Pot proceeds are customarily paid to the recipients about 45 days after coverage ends, so that the state earns interest on each pot for something over two and a half months. Some states sponsor two Life Games, one for those working regularly, the other for the unemployed. Payroll deduction plans make participation more convenient for full-time employees.

Is This For Real?

Is this scenario totally unrealistic? Not essentially. Competition between companies and agents for the consumers' insurance dollar has never been keener and profit margins and commission scales have been shrinking rapidly in response. The continually increasing sales requirements needed to support an average agent in a viable lifestyle make it increasingly uneconomical to deal with the small premiums and face amounts affordable by the lower 30% or 40% of the adult population. Actually, three dollars per month worth of insurance can't be bought in today's market. According to the 1990 Life Insurance Fact Book, the total number of individual life policies in force in the United States has been slowly declining since 1981 from 149 million to 144 million, even though the average face amount has grown over 150%.

The Life Game's popularity, as with other lottery-like games, stems from its informality, efficient opera-tion, and short-term nature. In any economic downturn, short-term objectives dominate the unemployed, those on fixed incomes or those in poor health who can't afford or qualify for individual policies. The countercyclical revenue obtainable from this segment of society could be enormous once it is realized that the average payout rate exceeds anything found in the private sector and the state sponsorship minimizes concern over irresponsible management practices. Also, the ease of buying a Life Game ticket compared with completing a life insurance application is a distinct advantage in today's fast-paced society.

The arguments—pro and con—for federal regulation of the insurance industry will be debated for years to come. The funding problem is unlikely to dominate the outcome of the debate, although tax considerations conceivably could. In the meantime, the Life Game will be lurking just over the horizon for those who want and need it most.

Source: Contingencies Magazine, January/February, 1991, pp 64-66

Recession-Proofing Insurance Companies

By Kenneth M. Heck

Are we in a recession? For the insurance industry, the answer is probably no, even though, for the economy as a whole, the answer is a definite yes. Historically, insurance has weathered economic downturns better than most industries, and the asset base has always increased year after year, even during the Great Depression. But what vulnerabilities are evident now that weren't concerns 10, 20, or 30 years ago? Let's name a few:

• Relaxation of investment restrictions has led to a greater percentage of riskier investments, which are more likely to wither with the onset of recession.

• The federal government, under pressure from Gramm-Rudman, is more likely to turn the screws on ' the insurance industry or, for that matter, on any other industry exhibiting substantial accumulations of surplus in their financial reports to stockholders and regulators.

• The sharply competitive nature of insurance sales prevents companies from recovering acquisition costs and generating book profits within a reasonable number of years. The prospects for profit from annual premium business tends to be little more than a gleam in the eye of the VP of sales, once lapses and termination have taken their toll.

• The outlook for substantial net capital inflows into the industry is questionable because of the declining cost of advanced technology. The observable decline in the cost of plant and equipment needed to support a given volume of business due to computerization, etc., inhibits large-scale investment from outside the industry.

These four elements, in combination with the onerous burden of state and federal regulation, could push a good many companies to the wall. Companies seeking to soften the imbroglio created by a recessionary economy may consider these four fundamental strategies.

1. Emphasize an investment orientation and lengthen the average premium payment mode to recoup acquisition costs more quickly. Payment modes of 2, 3, or even 5 years can be competitively viable when attractive discounts are offered. The lowest net cost should go to policyholders willing to invest more than the minimum amount of money to keep their coverage in force. Yes, this implies highly competitive rates for all forms of single premium and paid-up business, and stiff penalties for policy loans. The best customers should be single premium and paid-up customers—they evidently have sufficient faith in the product, and the company behind it, to fulfill their entire obligation at issue or paid-up time. In return, they de-serve the best efforts at service from both the agent and the central office staff. Money management and financial services need to be the watchwords, not such terms as "risk bearer" or "transfer payment entity." Insurance companies share or pool risks, but don't bear risk un-necessarily.

Products such as deferred annuities, especially tax-sheltered annuities, should be worthwhile if writ-ten on a service-charge basis only, and if contract owners are given the full benefit of the separate account concept. The freedom to choose specific securities in investing deferred annuity money is possible when a separate account is broken down into scores or hundreds of sub-accounts, each representing a single security satisfying the investment orientation of the separate account itself.

The right to specify sub-accounts and switch between them at will should be axiomatic in competing effectively with other financial entities (such as banks) for deferred annuity money. It would be perfectly legal to implement the sub-account concept immediately in a few states; others require a change in the law. However, a level playing field for all of the financial service institutions in this regard is well worth fighting for.

2. Immunize against operating losses by sharing profits and losses as much as necessary with employees and agents. In the cold, cruel, real world we live in, activities of any sort that aren't profitable can't be continually subsidized if any entity is to maintain financial integrity. Although the principle is clear, it seems difficult to get through to the company president and vice-president about why they can't draw their usual salaries and other perks when their organization experiences serious operating losses, or why an agent shouldn't receive a full first-year commission on a sale in which the insured dies after paying two annual premiums.

From the point of view of "pristine profitability," neither agent nor employee should be compensated for anything other than profits actually generated since inception of their start with the company. The fact that an insured's claim is really only a statistical phenomenon implies that the agent deserves only a little more than service charges until the policy is presumed to be generating book profits. At that time, the agent should begin to receive much more compensation in total than he would have under traditional arrangements.

The longer-term nature of the insurance profit-and-loss cycle must correspondingly lead to longer-term arrangements with agents and employees. It isn't unfair to base executive compensation directly on the bottom line over a specified time interval such as 5 years or more. Unexpectedly large amounts of profit should be squirreled away in retirement plans, or simply made unavailable for distribution for 3 to 5 years. Five-year plans of this sort can provide a mature challenge and release the creative energies of employees who should be concerned with the larger perspective.

Aren't stockholders in danger of being shortchanged by profit sharing plans of this type? In fact, the relative importance of capital to management and labor appears to be declining for the insurance industry, so stockholders may be taking more of a back seat in dictating the equitable division of profit among those actually generating it. There is no reason to believe an efficiently managed company won't be able to satisfy the legitimate demands of all parties involved in the insurance contract—policyholders, stockholders, creditors, agents, and employees—even during a prolonged recession. Long-term considerations may as well apply to stockholders as other parties. Generous dividends declared but not payable until 5 or 10 years later may effectively alleviate cash flow difficulties. In this situation, the corporation should have the option of paying out the dividends, in whole or in part, any time before the legal due date. A competitive rate of interest would be credited to the dividend liability until time of payout.

3. Write down equity assets to advantageous levels to reduce in-come taxes. The term "equity as-sets" may be unclear to some readers. Corporate assets can, conceptually, be divided into two categories—those acquired specifically to run the business, or equity assets, and those acquired or generated to satisfy liabilities of all kinds, or "debt assets." Normally, equity assets represent long-term investment in plant and equipment made possible by infusions of capital and surplus. They are sold (rather than depreciated or worn out) only if a company is confronting unusually disadvantageous conditions. Debt assets, on the other hand, are short or medium term, generated by sales or other revenue, and subject to predictable turnover cycles. For insurance companies, equity assets should include home office and branch office

buildings, large-scale computer installations, furniture and equipment, and all other items not originally intended to satisfy claims of policyholders or creditors at the time of purchase.

The write down suggested here can go far beyond traditional depreciation schedules and accounting methods. The following scenario illustrates the concept.

The date is February 5, 1996. Aquarian Life & Casualty, a stock company founded in the early 1960s, has grown such that its assets total several hundred million. Unfortunately, the longest recession on record has caught Aquarian management without realistic forward planning. Quietly implemented modifications in executive and agency compensation and the product mix haven't produced concrete results in the overall financial picture (depressingly gloomy). After perusing the statutory, FIT, and GAAP financials for 1995, the Board of Directors in a split decision determines to reduce income and property taxes by artificially lowering the appraised value of their main office building—the largest asset of the company.

A well-known firm of professional spray painters is hired the following week to decorate the walls and ceilings of every floor in a way that strikingly resembles outdoor graffiti. Garish colors and grotesque forms now begin to assault the eyes of every visitor. The corporation also opts to buy an electric scoring device to engrave the company name and employee names on all pieces of furniture and equipment. Outside, skilled artisans patiently drill a bigger company name and logo into the marble on three sides of the building.

After 3 months of this defacement campaign and the resulting publicity, the average market value of the building has dropped to less than 50% of its former value, according to five independent appraisal firms. All publicity, both favorable and unfavorable, is welcome from the company's point of view. Warning letters from IRS officials threatening legal action if the usual tax revenue isn't forth-coming for 1996 are put aside. Aquarian officers know they aren't the first—and won't be the last—company to temporarily downgrade equity assets in order to protect policyholder and stockholder funds from highly controversial tax laws.

Calendar year 1996 produces another statutory statement flowing with red ink. Deliberately so. But the turnaround has been accomplished both financially and psychologically. Of course, the solvency concerns of state regulatory authorities are assuaged, as usual, with a realistic valuation of assets and liabilities certified by a recognized actuarial firm. This is standard practice in the industry, since so many companies of all sizes are legally impaired but still permitted to operate on a restricted basis.

This scenario might appear to suggest a semi-hysterical solution to an intricate and difficult tax problem. However, all it really shows is just how far management might be willing to go to survive.

4. Resort to dedicated funding if claims patterns become abnormal, according to historical standards. It's a fact of life that both individuals and companies are most likely to get kicked when they're down. Likewise, poor or unpredictable claims experience can be anticipated when the economic environment is also depressed. The objective of dedicated funding is to limit a company's potential claim liability on any policy form to no more than total premiums paid in; plus, a perhaps predetermined percentage of company surplus.

Public relations considerations may dictate that all claims be eventually paid off, even though there is no legal obligation to do so. How-ever, this is preferable to the potential solvency problems that would be engendered by giving all claims equal legal status, regardless of size or type. Property/casualty and pension lines lend themselves most readily to the dedicated funding strategy, since they are more self-contained.

The theory and practice of recession-proofing are still in their in-fancy. But the good old days were never quite as good as they should have been. The best carriers have never (necessarily) enjoyed the lowest net cost figures, highest surplus, or highest dividends, commission, or salaries. Actually, only those companies that take the long-term interests of policyholders, stockholders, agents, and employees most seriously, deserve to be called the best. These will be the ones leading the industry in unprecedented measures to save corporate assets from the ravages of recession.

Source: the Actuarial Digest, February/March 1990, pp. 7, 16

Minimum Premium Plan - One Solution To Net Cost Competition

By Kenneth M. Heck

Severe price competition among life insurance companies in recent years has led to eroded expense and other margins traditionally considered necessary for a safe and sound operation. The question arises: If expense margins were really cut to the bone—the absolute minimum—what kind of coverage would the industry be promoting? The following scenario attempts to answer this rather difficult question.

It is February 4, 1994, Mr. and Mrs. Green of Des Moines, Iowa are both in their early thirties with one child. Mr. Green is a professional jeweler, although currently unemployed; Mrs. Green is working as a legal secretary. They have received an item of third class mail describing an odd-sounding life insurance plan. The headline screamed "YOU PAY NO PREMIUM UNTIL WE PAY A CLAIM!" Out of curiosity, Mr. Green called the toll-free number to ask a question about net cost.

"The minimum premium plan has no anticipated net cost, Mr. Green. Frankly, the Rigel Life people are sick and tired of useless net cost illustrations and indices. We do give you our expense charges and a history of premiums and claim payments since inception of the plan for your group. The real net cost for you and your wife is' simply your share of death claims as they occur plus our expense load. You could go years without paying a premium if there are no deaths in your group. Tomorrow is Saturday—why not drop in our local office in Des Moines about 10 o'clock and spend a few minutes with one of our representatives?"

Mr. Green reluctantly agreed; but knowing from experience how slick most sales explanations were, decided to enlist, Mr. Hapwell, the family financial planner.

"I can't make it tomorrow, Dan, but you can help by collecting all the documentation and then we'll get together next Thurs-day or Friday."

"I'll let you know," he replied. "Hap-well is always unavailable for the next five days for some reason," he thought to him-self.

The next day, Mr. and Mrs. Green had no difficulty locating Rigel Life's branch office. After introductions and preliminary small talk, Mr. Ellsworth, the company representative, continued on: "I believe we obtained your name from one of your old college friends. As a member of the fraternity you apparently qualify for up to $100,000 in coverage."

Mr. Green interrupted, "I'm not quite as interested in my fraternity as I used to be—they did a little too much drinking. What other groups are you connected with?"

Mr. Ellsworth handed him the complete computer listing for the last quarter. "Here are all the fraternities, sororities, lodges, professional and religious groups plus other non-profit entities. We are also considering the potential for neighborhood groups on a city by city basis. If Rigel could sign up 80 neighborhood referrals in Des Moines, you could perhaps belong to the Des Moines Plan, but our groups always have at least 80 people or we discontinue coverage."

"What are the requirements for joining?" asked Mrs. Green.

"You must possess a major credit card, be under 65 and satisfy our insurability requirements."

Mrs. Green was surprised. "Why do you need a credit card to qualify for life insurance?" she queried.

Mr. Ellsworth smiled. "You see, we don't depend on the usual premium notice and enclosed return envelope routine. Our notices simply inform you of what has al-ready been charged against your credit card. There are no checks written by you, so no reply to our notice is needed. Most clients prefer the pre-authorized check plan, but if your account is too low we would process the whole premium for the month through your credit card. Financially speaking, the best deal is with our variable deferred annuity. We deduct the premium from the annuity's earnings without jeopardizing the tax status of either. Both alter-natives incur less expense than the credit card transaction."

"Here it is," Mr. Green exclaimed, "The International Gemological Association. These people never allow themselves to be overcharged."

"Let me see one of your premium notices," Mrs. Green demanded.

"Here is a recent one for a member of Mr. Green's fraternity," Mr. Ellsworth re-plied. "First, we have a paragraph or two about the departed members, sometimes a small photograph, and address and phone number of surviving beneficiaries; then on page two, total amount paid beneficiaries plus our total expense charge for operating the plan and your relative share based on your attained age and amount of coverage. On page three we have current condition of the members' fund accumulated from the prior notice and a few membership statistics. You can see the fund here is positive, showing a little overpayment by members. We credit interest on members' funds at the T-bill rate."

"How can there be any overpayment if everyone pays only his share?" Mr. Green questioned.

"Well," replied Mr. Ellsworth, "the individual share amounts are always a little more than actually needed to pay claims to reflect anticipated withdrawals before a death occurs. Any positive or negative balance in the members' fund is used only to offset the next premium calculation. Actually, the minimum premium plan constitutes one of our most popular Depression products."

"Everyone says we are in an extended recession, not a depression." Mrs. Green responded.

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Mr. Ellsworth laughed. "Rigel Life calls it a recession when your neighbor loses his job and a depression when you lose yours."

"I'll second that," Mr. Green added with a smile.

"Isn't this plan really just an exotic form of assessment insurance?" Mrs. Green asked discontentedly.

"This coverage is a lot better than assessment insurance," replied Mr. Ellsworth. "No one will ever pay more than the maximum rates per thousand per year shown in your certificate, no matter how many deaths there are. Our maximums are about five times the standard rate. Also, our expense charges will never be more than the maximums indicated in the certificate. They depend only on size of group and size of premium. There are a few other charges for minor items such as a change in beneficiary or face amount. Those are all added to the figures shown on page two of the notice and displayed separately. But real assessment insurance has been illegal most of this century."

"Sure, but the premium will be bouncing up and down like a basketball," objected Mrs. Green.

"Yes, they could be a little erratic," Mr. Ellsworth agreed, "But our national economy isn't known for

level prices anymore. Show me a decent policy with level premiums and I'll show you a prime candidate for replacement in five years. The ones with frozen policy values lapse the most. Another thing, show me a company who will give you the names of all the people in your risk grouping. Rigel believes the better you know your group members, the better off both you and we are. Does that make sense? In any event, you can always pay off your credit card balance in any way you wish."

"How would we withdraw from the plan?" Mrs. Green asked.

"You need to notify us of your withdrawal date by mail or in person and complete the withdrawal form," responded Mr. Ellsworth, "then we make a final charge against your card or checking account for the coverage up to that point in time—something like a backend load. There is no return of your sign-up fee of $45; that is used to set up our computer records."

"Well, Jane, any more questions?" Mr. Green asked.

"Only one —how many times do these notices go out per year?"

Mr. Ellsworth rose to his feet with the others, "No more than once a quarter."

"Thank you for your time, Mr. Ellsworth; I'm sold on the concept, but we'll talk with our financial planner before signing anything," Mr. Green responded as he shook hands and steered Mrs. Green to-wards the door.

The Greens ultimately bought $100,000 of coverage and discontinued premium payments on their existing policy. Mr. Hapwell, their insurance specialist, retained the non-life insurance lines temporarily. Mr. Green corrected his mailing address with the International Gemological Association to permit all third class items to arrive at his home.

Rigel Life achieved its remarkable success by cultivating the recession or "depression" market. In contrast, at least one of its competitors is preparing to enter the higher socio-economic market of the very prosperous and very successful with its own brand of the minimum premium plan. All applicants will initially be assigned to one of four broad categories for premium classification purposes:

1. Business and Government Leadership

2. Scientific and Other Professional Disciplines

3. Sports, Entertainment and Media Personalities

4. Substantial Inherited Wealth Company representatives are presently searching for six or seven celebrities to publicly endorse their product. A second competitor has begun to successfully market the minimum premium plan to labor unions and employee groups through automatically deducting premiums from wage and salary checks.

Semi-assessment or quasi-assessment forms such as the minimum premium plan can have real potential for popularity since assessment policies were quite popular in their time. However, the mismanagement and disregard for elementary insurance principles traditionally associated with assessment coverage need not recur; the higher levels of regulation and professionalism expected of the industry today are a far cry from Nineteenth Century standards. One word of caution: no single pol-icy form can solve every possible insurance problem perfectly; also, no form can conceivably be better than the personnel behind it, beginning with the salesman on through to the state or federal regulator.

The seemingly disproportionate emphasis on low cost production in recent years is a natural phenomenon for any industry either approaching maturity or already mature. Mature industries are characterized by an absence of new fields to conquer. Authentic new business can arise only from population increases, productivity increases, or perhaps mandatory programs imposed by legislators upon society. The life insurance industry can be said to be mature to the extent that no individual company can enjoy a healthy gain in inforce policies without involving large numbers of lapses suffered by competitors. Consolidation of operations, increasing operating efficiency, and eliminating all unnecessary activities are the real means for company survival.

Source: Contingencies Magazine, January/February 1990, pp.62-3

Health Care Cost Containment

By Kenneth M. Heck

Serious efforts to contain health care costs over the past decade or more have not succeeded as well as expected. Other than a national health insurance system, are there any useful steps that could be taken? Where can we go from here?

The nature of doctor/patient relationships pervades most, if not all, aspects of health care delivery. The time has come to re-examine, reconceptualize, and reaffirm this relationship in light of modern technology and reimbursement patterns. Simply put, unnecessary costs arise from substandard or inferior doctor/ patient interactions. These costs must be contained or eliminated as much as possible.

Changing the Scenario

To contain or eliminate these unnecessary costs, let's consider the following scenario of a Health Care Organization (HCO) operating under the following conditions:

• All treatments prescribed by any physician belonging to the HCO are covered under the HCO benefit package if they are within the physician's area of professional specialty, are nonexperimental in nature, and are not for the physician himself or his relatives.

• No reimbursements for hospital or medical treatment can be made unless a physician's signature validates the claim—even down to the last aspirin. Peer review is resorted to in determining the reasonableness of questionable procedures. Second opinions are mandatory for highly expensive procedures.

• Realistic deductibles and coinsurance apply to the benefit package. A separate deductible may apply to prescription drugs. For physicians in their first year or two with the HCO, an aggregate limitation on covered charges for all patients, plus a limitation on covered charges per individual patient, may apply. These limitations may be removed or liberalized, after satisfactory ratings are obtained by the physician.

• Each physician in the HCO is subject to peer review, self-rating, and triennial rating according to criteria for professional effectiveness as assessed by organizations specializing in this function. Also, patients rate their physicians according to a satisfaction index so that an indication of average patient satisfaction can be developed for each physician.

Physicians not meeting the mini-mum standards can be excluded from the HCO or those subscriber groups within the HCO included in this benefit program. All HCO records are maintained on a physician basis in addition to the customary bases. The physician ratings are made available by HCO policy to HCO subscribers and certain specified consumer organizations.

• Premiums for subscribers to the HCO are calculated in the usual fashion. Rerating may occur annually or at six-month intervals. A risk charge implicit in the premium loading reflects the potential for adverse claim levels as usual. Profit begins to emerge when actual experience compares favorably with what is expected. If the total premium is less than an employer is willing to pay for other employees not in this benefit program, the difference may be returned to the employees in the form of higher benefits for unrelated coverages or incidentals such as free memberships in health and fitness clubs.

• At least one physician per HCO must specialize in examining patients and interpreting examination results. The Examining Physician uses specialized equipment—owned by the HCO—to perform an extensive battery of tests and obtain final results within the two or three hours allotted per individual exam.

All subscribers are required to obtain an examination at least once a year; those over 45 must have at least two per year. Refusal or failure to maintain the exam schedule constitutes sufficient grounds for terminating a subscriber's coverage. The primary care physician for any patient must never be the examining physician. The patient is always free to see his primary care physician for any reason independent of the mandatory examination requirement.

• The results of the battery of tests are recorded on a paper form that also shows the average test results for a normal person and the results the physician believes are most appropriate for that patient. The form also contains space for comments and recommendations by the physician.

Any deviation from the most appropriate results that cannot be solved by diet, exercise, or simple medication suffices as reason to set up an appointment with the primary care physician.

Both the patient and primary care physician receive a copy of the form. Patients not following the recommendations of the examining physician or their own physicians can receive an unfavorable rating for cooperation. Consistent lack of cooperation can result in termination of coverage.

• Each patient rates the physician performing any procedure, including the periodic exam, as an intrinsic part of the normal paperwork. Physicians rate patients in the same way. Written comments can be made explaining the ratings. All ratings made by patients and physicians are fed into a computer program for statistical processing. When disagreements over ratings or requests made to transfer patients or physicians out of the program arise, an Adjudicating Physician makes the final decision or judgment. Adjudicating Physicians cannot be primary care physicians and normally do not engage in a full practice.

Establishing Objectivity and Balance

Is this schema too harsh or rigorous for the American health market? I believe not. The division of labor between the examining and primary care physicians is bound to be controversial, but objectivity with periodic examinations plus access to sophisticated testing equipment not normally found in most physicians' offices should pay off.

Patients, or subscribers, must come to realize that merely remitting high health care premiums cannot be enough to guarantee high-quality health care. Sincere cooperation in elementary matters such as diet and exercise must inevitably become a prerequisite for access to highly expensive treatments. Patients unwilling or unable to cooperate fully will eventually have to pay their legitimate share of health costs rather than enjoying a subsidy from healthier patients. This hypothetical HCO emphasizes full cooperation and communication between patients and doctors and not attaining perfect physical condition. In fact, only a few applicants would be rejected as uninsurable.

Physicians Hold the Key

The final responsibility for health costs should rest with physicians, both in theory and practice. The concept of unlimited coverage returns the health cost spotlight on its original subject, the practicing physician. Traditional health insurance contracts, by specifying what is covered and what is not, have unwittingly shifted part of the responsibility for health costs to the insurance industry. The industry must extricate itself from its unintended third-party role.

Physicians unwilling or unable to live with objective ratings should not presume that insurance plans will always provide compensation for services rendered. The appropriate clientele for these physicians should be limited to the very rich or the very poor, neither of whom are health insurance oriented.

And the Uninsurable?

What about those who are or will become uninsurable? The preferred solution involves a national plan similar to the Comprehensive Health Plans for uninsurables currently operating in a handful of states.

Although requiring federal legislation, day-to-day administration should be left to a single body such as the National Association of Insurance Commissioners (NAIC) rather than the federal government or private organizations. Under the national plan, existing state plans would be preempted unless they offered higher benefits than the national plan. The NAIC Administrative Center would process claims and premiums.

Also, the excess of claims over premiums would be subtracted from state premium taxes on a state-by-state basis, so that no state would be • responsible for more than the extra cost of uninsurables actually residing within its borders. The premiums paid by uninsurables would be truncated at a level no more than 50% above the cost for standard risks for the benefits provided. This approach obtains a greater spread of risk across the county and significant economies of scale from the expense standpoint, without seriously violating the principle of state regulation of insurance.

Source: Contingencies Magazine

Dedicated Funding

By Kenneth M. Heck

The date is August 1, 2010. At approximately 4:00 p.m. on a local highway, on the outskirts of a densely populated Midwestern city, a large truck carrying a highly toxic gas used in military-industrial processes overturns, killing the driver instantaneously and blocking traffic in both directions. The gas, odorless and invisible, begins to escape to form a dense cloud. The weather is such that the gas attains its maximum potency. Unfortunately, the rush-hour traffic has just begun, and vehicles back up for 5 miles before any hint of what has happened reaches the authorities.

Most of the drivers in the vicinity succumb, though a few manage to save their lives by evacuating their cars and breathing through heavy cloth. The enormous death toll affects one medium-sized life insurance company with particular severity, since a large number of highly insured employees perish, as well as substantial numbers of employees of local firms that have group life coverage with the company. Because of especially unfavorable economic conditions and morbidity/ annuity experience for the last four years, the company is currently operating on a razor-thin surplus margin, barely above the legal minimum. In normal circumstances, in spite of reinsurance, sustaining these losses would qualify the company for immediate regulatory attention. But, thanks to intelligent implementation of a dedicated funding program three years earlier, no regulatory intervention, insoluble cash flow problems, or drainage of assets from unrelated lines of business occurs. The company escapes a financial disaster that would have subjected nearly every company its size to rehabilitation or receivership just ten years before. Too good to be true?

The Concept of Dedicated Funding

Dedicated funding is simply a sophisticated form of self-insurance that is particularly appropriate for the technology-dependent, densely populated conditions of American society in the 1980s, 90s, and beyond. Another term for dedicated funding is "U-insurance," since the fund supporting the insurance contracts tends to fluctuate under the Catastrophe Provision, to form an irregular series of U's, as claims are paid and premiums are received.

Under self-insurance, the self-insurer determines who is to be insured, policy language, benefits payable, and required contributions. The third-party administrator (TPA) functions in a neutral capacity in administering plan provisions and plan assets. Under U-insurance, the TPA or financial services entity (FSE) aggressively markets standardized coverage programs for both groups and individuals, screens the risks, collects contributions precalculated by its own actuaries, and terminates coverage for nonpayment of such contributions.

Like self-insurance, U-insurance offers recognized advantages:

1. Small (or no) state premium tax.

2. No state or federal income taxes arising from policyholder funds. Only the FSE itself is subject to income taxes.

3. The legal liability of the FSE is limited to policyholder funds only, regardless of individual or specific claims arising from policyholders. Also, no fund is liable for claims arising from any other funds administered by the FSE.

4. The burden of state and federal regulation is substantially smaller.

The insurance company in the scenario had founded the FSE as a wholly owned subsidiary with an initial capitalization of $2.5 million in stock. In addition to a conversion program for group business over to the U-insurance basis, the company had recently initiated a direct-response program for consumers receptive to the idea of buying U insurance through the mail. These U-insurance contracts have several distinctive features.

Premium Payments

Premiums are predetermined by the actuarial staff of the FSE. Rerating occurs at six-month intervals. The expense element in the premium is automatically credited to the FSE gross income account when the premium is collected. The rest of the premium goes to the appropriate policyholder fund, out of which benefits are paid to covered insureds only.

The FSE maintains only three funds. The term "dedicated funding" implies that the fund disbursements are dedicated to insureds only; all expenses of operation must be taken out of the premium before it enters the policy-holder fund. Specific charges that accrue against groups of insureds for specific services beyond the minimum expense charges are added to the next premium notice. There is no current requirement that FSE and policyholder assets be kept physically separate, but separation does look like an emerging trend among the newer FSEs.

By invoking the Catastrophe Provision, the FSE can require an extra or additional premium beyond the normal level at any time. There is no obligation to wait until the end of a six-month rerating period to adjust premium levels if a catastrophe has been formally declared. Those who refuse to pay the amount required forfeit their coverage.

The Catastrophe Provision

Whenever expected claim payments exceed a specified percentage of the fund plus expected contributions during the rating period, the FSE has the right to enter the catastrophe mode of operation. All insureds covered by the fund involved, as well as the regulatory authorities, must be notified of this decision by registered mail. The FSE maintains the right to change premium levels at any time, and as often as it wishes, while in the catastrophe mode.

All death claims occurring after a specified date—the catastrophe date—must be segregated by size into four levels of payment priority:

1. Claims of less than $50,000.
2. Claims of $50,000 or more but less than $250,000.
3. Claims of $250,000 or more but less than $750,000.
4. Claims of $750,000 or more.

All current priority-one claims must be in a paid position before priority-two claims are settled (etc.). Within each level of priority, claims are paid according to chronological order of occurrence. In the instance of a $500,000 claim, the first $50,000 would be paid according to level-one chronological priority; the next $200,000, according to level-two chronological priority; and the last $250,000, according to level-three chronological priority.

The catastrophe mode continues until all claims assigned a priority status have been settled (usually a matter of years). Again, this requires notification of all existing insured and regulators by mail. After fifteen years in the catastrophe mode, any outstanding unpaid claims lose their legal status if the. FSE chooses to exercise its legal right to terminate the fund's legal existence at that time. (This is distinguished from discontinuation of the plan of insurance itself.)

The FSE has the right to discontinue any plan upon giving six months' written notice. Terminating the plan has the effect of truncating or eliminating contributions to the fund. Any insured whose coverage has been terminated is offered an opportunity to qualify for coverage under a new fund set up for the express purpose of conserving customers.

Reinsurance

The FSE covers each fund with reinsurance, defined in terms of expected annual claims. This quantity is simply the claim component of the gross premium and corresponds closely to the amounts credited to the policyholder funds. For the fund in question, the reinsurance coverage had been set at 2.00 times expected claims, up to 4.00 times expected annual claims. This amount was considered realistic, because the types of events that could conceivably cause greater losses were considered to be of national importance only. (The magnitude of the toxic gas disaster discredited this view.)

Start-up and Other Costs

Strict accounting applies to all start-up costs, so that no fund or policyholder is inadvertently overcharged. Charges for normal operating costs are subject to little leeway, and the actual profit margin on all expense charges is considered public knowledge. There is no secrecy about this information, so that the organization can garner full public confidence and general goodwill. (However, information about policy-holder• contracts is considered confidential.)

Investment Orientation

Contributions to policyholder funds are invested in short-term securities only. Investment expenses are deductible only from interest earnings; the principal is never touched. Insureds who have personal savings plans with the FSE invest their money according to specified investment objectives, as if each owned his own personal separate account. More favorable premium rates apply to the funds that stipulate a mini-mum level of personal savings per death benefit.

FSE Insolvency

In the event of a hopeless FSE insolvency, the insurance department of the domiciliary state is legally required to transfer all policyholder funds and ac-counts to another FSE or insurance company. The process tends to be less painful than the typical insurance company insolvency since there is no question about- the insufficiency of policyholder funds.

Only stockholders, bondholders, and other creditors suffer the full brunt of the FSE insolvency (besides employees).

FSEs vs. Insurers

What are the ultimate differences between this FSE and a traditional insurance company of comparable size?

Two major aspects come to mind: (1) the FSE segregates expense charges from policyholder funds, and (2) no unassigned policyholder surplus is needed to operate the FSE.

The first distinction represents the net premium concept carried to its logical conclusion. From the point of view of the general public, the loading of any gross premium represents the commercial element of an insurance contract, and the net premium its fiduciary element. The concept of dedicated funding therefore corresponds more closely to the public understanding in regard to insurers' fiduciary responsibility.

Discriminating between fiduciary and commercial objectives has .always been problematical for traditional insurance companies, since these objectives can readily overlap. Those companies that prefer the corporate gain or loss concept over the net premium concept will inevitably be subject to much the same general federal income tax formula as any other corporate entity. But this is the price to be paid, if a corporation is to preserve its freedom to manage insurance funds primarily for its own advantage.

The second distinction is more apparent than real. No FSE would contemplate operating without an element of padding (conservatism) in the premium rates credited to policy-holder funds. In fact, the FSE model constitutes one method of building surplus policyholder funds according to management objectives, without unnecessary hindrance from regulators.

The real distinction between the two operating modes lies in the degree of professionalism presumed. The FSE must always be on the alert in monitoring experience and anticipating future developments, since no surplus cushion mitigates its fiduciary obligations.

The traditional insurance mode can be properly compared to a tricycle—the front wheel represents management- expertise and integrity, and the two back wheels, policyholder funds and required surplus (the metal frame can stand for the regulatory and environmental framework). In contrast, the FSE is analogous to a bicycle, where the one back wheel symbolizes policyholder funds only. Of course, tricycles seem to be safer, and you don't need any training to enjoy one. But for getting where you want to go, bicycles are obviously the superior choice. In fact, it would be difficult to find anyone who regretted learning to ride one.

New Ideas for the Nineties

Part I

By Kenneth M. Heck

The insurance industry has witnessed a rising tide of criticism regarding traditional modes of operation during the Eighties. This phenomenon originates both within and without the industry and reflects no single psychology or philosophy. The well-known issues, among others, are as follows:

1. Unisex rating.

2. Banks entering the insurance industry.

3. Repeal of anti-rebating laws.

4. Removal of the anti-trust exemption.

5. Proliferation of the "buy term and invest the difference" philosophy.

6. Taxation of the "inside buildup" of cash value policies.

The resistance of the industry to inappropriate changes or innovations must continue on. This includes all the standard tactics and strategy, including sponsoring public education, supporting favorable candidates for political office, lobbying legislators, and mass advertising. However, resistance or opposition is not enough; constructive thinking is a necessary ingredient in any recipe, for ultimate success. This series of articles concerns itself exclusively with new ideas and constructive thinking. The initial article outlines potential developments in the insurance mechanism for life and health coverage.

I. SEPARATION OF COMPONENTS - LIFE

The scenario is the late 1990's. Lotteries are now operating in almost all fifty states. Their ability to generate predictable tax revenue has led to widespread acceptance. A new kind of lottery, called the "Estate Lottery", or more popularly, the "Death Lottery" has recently been initiated in several of the more populous states. Under this form, lottery proceeds are payable to the estate of those holding tickets, but die natural deaths during the period of coverage provided by lottery rules. Death Lottery proponents have successfully argued that lottery proceeds payable on this basis possess greater social utility compared to proceeds paid to living winners - many of whom do not adjust satisfactorily to their new-found wealth.

Under the Death Lottery, tickets can be bought anytime during the month prior to the beginning of coverage. The cost varies according to a predetermined premium scale; the simplest scale involves only three age brackets. To participate, a person must only be actively employed at the time of ticket purchase. Of course, suicides and homicides are not covered and lottery representatives investigate all deaths reported to the lottery. Participants may purchase up to ten tickets each. Multiple ticket purchases make

the game more interesting and unpredictable. The rules are quite specific as to all possible outcomes arising from multiple ticket winners. The lottery operates concurrently during enrollment periods so full coverage is possible at all times. The coverage lasts three months, or until 13 deaths occur, whichever comes first. However, coverage must continue until at least one death occurs. The proceeds of all ticket sales are combined together into one pot, out of which the state takes perhaps a 9% excise tax plus a 1% administrative fee. As deaths occur and are reported to the lottery they are assigned a number corresponding to their chronological sequence. At the end of the coverage period, 13 or fewer balls form the basis of a drawing. The numbers on the ball represent the sequence of death. Number 1, for instance, represents the person dying first, number 8 the person dying 8th, etc. These balls are subjected to the customary randomizing techniques and are mechanically drawn one after another during the formal lottery session (a monthly or bimonthly event). The first few balls drawn receive a prize large enough to pay little more than burial expenses, or a specified minimum amount. The prizes increase in value until only the final two or three balls are left; these divide up the bulk of the pot with the final ball receiving the grand prize. However, one state has refused to implement the lottery element by requiring that all proceeds be divided equally between winning tickets.

Is this gambling with insurance overtones or insurance with gambling overtones? Those who never gamble would call it gambling; those who never buy insurance would call it insurance. Whatever it is, public acceptance of legalized gambling is growing and with it a stronger public gambling psychology or predisposition.

In situations of widespread overinsurance, such as happens where economic conditions cause high unemployment or financial hardship, the element of gambling becomes greater than insurance companies would be comfortable with. From the point of view of public psychology, distinguishing the beneficiary of a very large death claim from the beneficiary of a Death Lottery could be difficult. Also, the actual disposition of the proceeds of a life insurance policy may support a gambling psychology.

Despite the best possible financial counseling or planning from highly trained professionals, very few life policies issued today can guarantee that the proceeds will necessarily be applied according to the original intention of the policyowners. To the extent the insured's original intention is ignored by beneficiaries, or overinsurance exists, the insurance mechanism has not served its purpose.

All uncertainty concerning the exact operation of the insurance concept or mechanism must (and ultimately will be) minimized or eliminated entirely. As a result, questions or taxation and regulation of insurance will remain free of gambling considerations, despite critics who would apply a common frame of reference to both.

The life insurance industry will ultimately be appealing to the concept of separation of components to further refine the distinction between true gambling and legitimate insurance contracts. Under this concept the reasons for insurance as developed during the initial underwriting process become an integral part of the policy itself. For example, a man with a dependent wife and two children might draw up his contract as follows:

1. Clean Up Fund - Actual Expenses up to $25,000 maximum.

2. Estate Tax Coverage - Actual Taxes up to $500,000 maximum.

3. Monthly Income for Wife - $2,000 per month for life, terminating upon remarriage and reduced by earnings from employment.

4. Monthly Income for Child Support - $500 each up to age 25 or graduation from college, whichever occurs later.

5. Childrens' Education Fund - Up to $10,000 for each year of college, payable only upon actual attendance.

Benefits 1, 2 and 5 are payable upon receipt of proof or evidence of actual expense. Original copies of bills would usually be sufficient. Benefits 3 and 4 are subject to periodic redetermination. Each of these benefits develops a gross premium and reserve. The total gross premium is simply the sum of the components. The similarity to A & H coverage is clear.

Separation of death benefits into standardized components and the consequent burden of administration emphasizes the fiduciary nature of insurance companies in solving true financial problems. Those companies willing to accept the higher degree of responsibility inherent in this function are the ones to survive and thrive into the next century.

Ia. SEPARATION OF COMPONENTS - LONG-TERM DISABILITY

The development and promulgation of rehabilitation benefits, cost of living adjustments, partial disability benefits, survivor income benefits, improved definitions of disability, etc., make today's long-term disability product vastly superior to those sold just before the Depression of the Thirties.

However, from the insured's point of view there remains much room for further development in terms of actual coverage needed at any given time. Benefit determination today is largely a matter of a fixed percentage of in-come reduced by other payments. The resulting monthly benefit does not fluctuate during the period of disability. What is not explicitly recognized in most benefit formulas are such factors as:

1. Existence of dependent spouse and children.

2. Actual mortgage and other monthly debt payments.

3. Minimum monthly payments for house maintenance (electricity, water, etc.).

4. Payments made into savings programs or for insurance coverage.

5. Income from all other sources besides salary.

The separation of components concept combined with modern computer systems will enable insurers to incorporate all relevant factors into one comprehensive benefit formula tailored to the group or individual covered. Each component of coverage will possess its own standard policy language, premium and reserve development and maximum level of benefit payable. An overall maximum payout per month may

also apply, regardless of the total benefits obtained by summing the components. For some components, redetermination of actual benefit payout will occur perhaps as often or oftener than the disability status itself is revalidated.

Why did the industry have such poor experience with disability coverage during the Thirties? It seems to me that a large portion of the problem involved a rather imperfect comprehension of the insurance mechanism. In oversimplified terms, instead of paying off the mortgage, carriers were mailing checks to disabled insureds to spend as they saw fit. Integration with other sources of income was negligible, and no policy provisions existed to adjust payments to changes in economic status once disability began.

No one would dispute in this machine era that the component parts of a mechanical device must be precisely designed to specified tolerances for the machine to perform efficiently. The same reasoning applies to the insurance mechanism. The insurance mechanism is bound to improve in efficiency as the insurance industry itself continues to develop and evolve along with society as a whole. Past standards of efficiency and performance will inevitably be left behind in much the same way that ditch-digging jobs for unskilled laborers have been eliminated. In the case of insurance the new tools are primarily advanced computer systems and communication equipment.

II. DEDICATED FUNDING

The date is August 1, 2010. At approximately 4:00 p.m. on a local highway within the outskirts of a populous Midwestern city, a large truck carrying highly toxic gas used in military-industrial processes overturns, killing the driver instantaneously and blocking traffic in both directions. The gas, odorless and invisible, begins to escape to form a dense cloud. Ideal weather conditions exist for optimum lethal potency. Unfortunately, the rush hour traffic has just begun and backs up for five miles before any hint of what has happened reaches the authorities. The victims of the gas are usually slouched over the wheel in their cars. A handful of drivers manage to save their lives by leaving their cars and breathing only through a heavy cloth. The enormous death toll affects one medium-sized life insurance company particularly severely since a large number of highly-insured employees perish plus substantial numbers of employees of local firms which have group life coverage with the company.

Due to particularly unfavorable economic conditions and morbidity/annuity experience for the last four years the company is currently operating on a razor-thin surplus margin barely above the legal minimum. Normally, in spite of reinsurance, sustaining these losses would qualify the company for immediate regulatory attention. But, thanks to intelligent implementation of a dedicated funding program three years prior, no regulatory intervention, insoluble cash flow problems or drainage of assets from unrelated lines of business occurs. The company escapes a financial disaster that would have subjected almost all companies its size to rehabilitation or receivership only 10 years before. Too good to be true?

Dedicated funding (I prefer to call it U-insurance or you-insurance) is simply a sophisticated form of self-insurance appropriate for the highly technological, densely populated conditions of American society in the Eighties, Nineties and beyond. Under self-insurance, the self-insurer determines who is to be insured, policy language, benefits payable and required contributions. The TPA or ASO firm functions in a neutral capacity in administering plan provisions and plan assets. Under U-insurance, the TPA or Financial Services Entity (FSE) aggressively markets standardized coverage programs for both groups and

individuals, screens the risks, collects contributions precalculated by its own actuaries, and terminates coverage for nonpayment of such contributions.

As with self-insurance, U-insurance possesses known advantages:

1. Small or no state premium tax.

2. No state or federal income taxes arising from policyholder funds. Only the FSE itself is subject to income taxes.

3. The legal liability of the FSE is limited to policyholder funds only, regardless of individual or specific claims arising from policyholders. Also, no fund is liable for claims arising from any other funds administered by the FSE.

4. The burden of state and federal regulation is substantially smaller.

The insurance company founded the FSE as a wholly-owned subsidiary with an initial capitalization of $2,500,000 in stock. In addition to a conversion program for group business over to the U-insurance basis, the company had recently initiated a direct-response program for individuals receptive to buying U-insurance through the mail. The distinctive features of these U-insurance contracts:

1. **Premium Payments** - Premiums are predetermined by the actuarial staff of the FSE. Rerating occurs at six-month intervals. The expense element in the premium is automatically credited to the FSE gross income account when the premium is collected. The rest of the premium goes to the appropriate policy-holder fund, out of which benefits are paid to covered insureds only The FSE maintains only three funds. The term "dedicated funding" implies that the fund disbursements are dedicated to insureds only; all expenses of operation must be taken out of the premium before it enters the policyholder fund. Specific charges that accrue against groups or insureds for specific services beyond the minimum expense charges are added to the next premium notice. Physical separation of FSE and policyholder assets is not currently required but constitutes a growing trend among recently formed FSE's. By invoking the Catastrophe Provision, the FSE can require an extra or additional premium or premiums beyond the normal level at any time. There is no obligation to wait to the end of a six-month rerating period to adjust premium levels if a catastrophe has been formally declared. Those who refuse to pay the amount required forfeit their coverage.

2. **The Catastrophe Provision** - Whenever expected claim payments exceed a specified percentage of the fund plus expected contributions during the rating period the FSE has the right to enter the catastrophe mode of operation. All insureds covered by the fund involved plus the regulatory authorities must be notified of this decision by registered mail. The FSE has the right to change premium levels at any time and as often as it wishes while in the catastrophe mode. All death claims occurring after a specified date - the catastrophe date - must be segregated by size into four levels of payment priority:

1. Claims of under $50,000.

2. Claims of $50,000 or more but less than $250,000.

3. Claims of $250,000 or more but less than $750,000.

4. Claims of $750,000 or more.

All current priority one claims must be in a paid position before priority two claims are settled, etc. Within each level of priority claims are paid according to chronological order of occurrence. For example, a $500,000 claim would have the first $50,000 paid according to level one chronological priority, the next $200,000 according to level two chronological priority, and the last $250,000 according to level three chronological priority.

The catastrophe mode continues until all claims assigned a priority status have been settled (usually a matter of years). Again, this requires notification of all existing insureds and regulators by mail. After 15 years in the catastrophe mode, any outstanding unpaid claims lose their legal status if the FSE chooses to exercise its legal right to terminate the fund's legal existence at that time. This is in distinction to discontinuing the plan of insurance itself. The FSE has the right to dis-continue any plan upon giving six month's written notice. Terminating the plan has the effect of truncating or eliminating contributions to the fund. Those who are terminated are always offered an opportunity to qualify for coverage under a new fund set up for the express purpose of conserving customers.

3. **Reinsurance** - The FSE covers each fund with reinsurance defined in terms of expected annual claims. This quantity is simply the claim component of the gross premium and corresponds closely with the amounts credited to the policyholder funds. For the fund in question, the reinsurance coverage had been set 2.00 times expected claims up to 4.00 times expected annual claims. This amount was considered realistic since the types of events which could conceivably cause greater losses were considered to be of national importance only. The gas disaster discredited this view.

4. **Start-Up and Other Costs** - Strict accounting applies to all start-up costs so that no fund or policyholder is inadvertently overcharged. Charges for normal operating costs are subject to little leeway and the actual profit margin on all expense charges is considered public knowledge. No secrecy exists in this area in order to gain full public confidence and goodwill. Information related to policyholder contracts is considered confidential.

5. **Investment Orientation** - Contributions to policyholder funds are invested in short-term securities only. Investment expenses are deductible only from interest earnings; the principal is never touched. Insureds with personal savings plans with the FSE invest their money according to specified investment objectives as if each owned his own personal separate ac-count. More favorable premium rates apply to the funds which require a minimum level of personal savings per death benefit.

6. **FSE Insolvency** - In the event of hopeless FSE insolvency, the insurance department of the state of domicile has the legal duty to transfer all policyholder funds and accounts to another FSE or insurance company. The process tends to be less painful than the typical insurance company insolvency since no question of insufficiency of policyholder funds arises. Only stockholders, bondholders and other creditors suffer the full brunt of the FSE insolvency (besides employees).

What are the ultimate differences between this FSE and a normal insurance company of the same size? Perhaps two:

1. The FSE segregates expense charges from policyholder funds.

2. No unassigned policyholder surplus is needed to operate the, FSE.

The first distinction represents the net premium principle carried to its logical conclusion. Those companies which would not want to be bound to the net premium basis, preferring instead the corporate gain or loss concept, will inevitably wind up subject to the same FIT formula as any other financial entity. This is the price to be paid in maintaining freedom in managing insurance funds for corporate advantage. Alternatively, those which adhere to the net premium basis do not believe in employing policy-holder funds for corporate purposes only, but prefer to see themselves as custodians of a sacred trust in preserving policyholder funds to the extent practicable. Companies currently emphasizing gross premium valuation in determining surplus tend to emphasize company objectives in distinction to policyholder objectives. The reverse applies to companies emphasizing net premium valuation.

The insurance industry began with the net premium concept and will ultimately be successful in preserving it amid the conflicting demands of stockholders, bondholders, creditors, agents, employees and the taxation and regulatory aspirations of federal and state agencies, but it will take a good deal of initiative and expertise. The FSE model described here represents one way of resolving the differences between net and gross premium considerations.

The second distinction is more apparent than real. No FSE would contemplate operating without an element of padding or conservatism in the premium rates credited to policyholder funds. In fact, the FSE model constitutes one method of building surplus policyholder funds according to management objectives without unnecessary hindrance from regulators. The real distinction between the two operating modes lies in the degree of professionalism presumed. The FSE must always be on the alert in monitoring experience and anticipating future developments since no surplus cushion mitigates its fiduciary obligations.

The traditional insurance mode can properly be compared to a tricycle ¬the front wheel representing management expertise and integrity and the two back wheels policyholder funds and required surplus (the metal frame represents the regulatory and environmental framework). The FSE is analogous to a bicycle where the one back wheel symbolizes policyholder funds only. Of course, tricycles appear to be safer and require no training to enjoy. However, for getting where you wish to go, bicycles are more effective for most individuals and provide more enjoyment than tricycles for those who can operate them. In fact, very few individuals have ever regretted learning how to ride one.

III. ASSET-ORIENTED INSURANCE

The year is 2015. A financial planner is appraising the insurance needs of his client. He works for one financial services company (rather, group of companies) only.

"Look, he continues on, we both realize you need this protection program, you own these assets, earn the monthly salary, and your medical record is excellent."

"The only question to consider is where to get the best price for your insurance coverage. Let me type everything into my screen."

The client is visibly moved as the screen displays the initial premium payment. "Is that right?," he gulps. "Your figure is almost 30% below my last quotation."

"I can rerun it on a larger computer at the office," the planner replies, "but for your age and lifestyle this amount isn't surprising. Of course, you will transfer all your assets and other business over to our conglomerate and use only facilities displaying our logo."

"But what does my checking account and new car have to do with the cost of insurance?," the client objects.

"Believe it or not, by centralizing your financial affairs with one specific organization your insurance costs plummet because the insurance mechanism operates more efficiently. Your insurance will protect your dependents against loss or erosion of assets, including your earning power if you die, right? Well, putting them all under one roof with a policy that automatically adjusts benefit levels and premium rates as the assets themselves are added to or subtracted from gives you the most precise coverage and least cost of insurance possible."

"Are there statistics to prove that?" the client questions.

"Yes there are," answers the planner, "but it has always been true, even in the days of the old straight life, cash value policies. Plans developing cash values had lower mortality, persistency and even expense rates compared to non-cash value plans once the cash values appeared. The reason was that the cash value represented in a primitive way a small part of the insured's assets or estate. This tenuous connection between the coverage and the estate is what really built the insurance industry in the 20th century."

"Do you still sell this type of coverage?" asks the client.

"I don't and neither does my company - only a handful of specialty companies would sell you coverage designed according to 1965 standards today."

"Why not?"

"Well," continues the planner, "there are too many fixed quantities to computerize the product successfully; imagine all the numbers generated for a single client where specific premiums, death benefits, nonforfeiture values, and commission payments are pre-assigned to each duration, besides the policy provisions themselves. Our central office would be full of nothing but client data files!"

With a sigh of acceptance, the client moves to sign the dozen or so documents in the places indicated and begins handing them to his wife for her signature.

The planner appears relieved and concludes his interview in his customary fashion. "You will receive your new credit cards in three days, also a booklet detailing the services our companies offer. Your free safety deposit box should contain the titles to each asset we listed on this form by the end of this month. Of course, everything relating to investments will be handled by our securities people. The new will is

dated to go into effect next month simultaneously with your coverage. I will need to see you both again two or three weeks from now."

This scenario, although a bit overdrawn, illustrates one of two general directions life insurance companies will be pursuing in the future. The first, the fully integrated financial services concept, implies that it is both possible and reasonable to design and price coverage based on complete knowledge of the insured's financial circumstances. The second direction is illustrated by the "buy term and invest the difference" philosophy where only partial knowledge is required and only insurance is sold. Both directions are valid, depending upon circumstances, although the first will appeal to the overwhelming majority of policyholders as it continues to develop and gain credence. Rather than discussing the ramifications of these divergent trends or the banking issue, I will conclude by describing several developments the industry is likely to experience in pursuing the first direction.

Single premium plans will continue to proliferate and expand. Single premium five and ten year term, disability, and accidental death will be popular options to annual payment plans. Also premiums paid in advance and other asset-attracting measures will grow in importance as the distinction between experience of plans with associated funds and plans without associated funds becomes more fully analyzed and appreciated.

One popular, competively priced product will be a whole life rider to a deferred annuity plan. The rates for the rider will increase automatically so as to approximate a level term rate if the annuity account value falls below a critical point. The face amount will also reduce to the term issue limit. Increases in death benefit will be governed by predetermined underwriting procedures specified in the rider provisions. Insurance costs will be deducted from interest earned by the deferred annuity primarily or secondarily paid by an additional contribution by the insured. The annuity will be free of premium tax and tax-deferred for FIT purposes. Its provisions will be quite flexible and competitive with bank savings accounts and TSA's.

Also, the separate account concept will be vastly expanded to permit individual and group policyholders to invest in particular securities. Each separate account will contain dozens or hundreds of sub-accounts, the vast majority of which represent a particular stock or bond. Each sub-account will be designated by an identifying number, and the insured will be able to choose any sub-account or combination of sub-accounts in investing his funds. The insured's portfolio under this arrangement will form the basis for advantageously priced life, disability and medical coverage under a group trust agreement.

New state and federal regulations will be limited to eliminating loopholes and special advantages enjoyed by different types of financial services companies so that a level playing field applies to all participants. The ultimate idea will be that those companies which take the consumer most seriously will dominate the financial services area, regardless of company origin or ownership history. The consumer reigns supreme in the next century."

Part II

Do identifiable long-term trends exist for the L & H insurance industry? Is it possible for carriers to position themselves advantageously by adapting to these trends? I believe the answer to both questions is yes. This Part briefly discusses several trends I believe exist now and should continue for the foreseeable

future as part of the overall trend toward more precise understanding and operation of the insurance mechanism.

I. TOTAL COVERAGE

The long-term trend is toward complete coverage rather than partial coverages as exemplified by the cancer policy, the dread disease policy or the accidental death benefit rider. Discriminating between types of death, disability or medical conditions for insurance purposes is becoming more and more unnecessary as advances in medical science continue to erode any distinctions that insurers or the public may consider justifiable.

The accidental death benefit, for example, clearly served a useful purpose in the early days of the industry, where hospitals, physicians, and ambulances were in short supply or non-existent. Today, many accident victims stand a good chance of receiving medical care and surviving. Also, the intrinsic nature of accidents has changed over time. Today's relatively reliable technology runs almost indefinitely with proper care and maintenance. Accidents related to today's technology tend more and more to be caused by human negligence or sabotage, not imperfect design or manufacturing techniques. True accidents in the Nineteenth century sense are be-coming too atypical to be successfully covered. Unfortunately, further modifications in the policy definition of accident may not be totally successful. The money spent for this benefit would be better spent on providing disability coverage and medical care after the injury. The reasoning is that money should be spent to save life, not to provide an incentive to die in the form of higher policy proceeds.

As partial coverage policies become less relevant or necessary their experience will tend to deteriorate and premiums rise to unattractive levels because the kind of people seeking these coverages will be less desirable risks generally speaking. In other words, anti-selection will become a severe problem for policies or coverage lacking sufficient social utility or cogency. In the case of accidental death, coverage while traveling on common carriers such as planes, ships or trains will continue to possess cogency since these deaths still approximate the classical conditions.

Accident Endowment Plan

An accidental death policy carrying high cash values as an alternative (not a supplement) to full coverage for younger insureds does have some marketability. At the younger ages, where injury or accident is an important cause of death relative to disease, many persons characteristically feel that the prospect of dying from disease is too remote to insure against. For them, the best idea could be the "accident endowment" plan. This plan is characterized by the following:

1. Provides accidental death coverage only, or may also cover disabilities in the standard manner.

2. Issued from ages 18 to 40. The policy matures as an endowment at age 55 for the full face amount or a specified percentage of the face amount.

3. The insured may convert to full coverage at any time up to age 55 by exercising the conversion option. The cost of conversion is divided between a premium expense charge and a specific charge against the

cash value at the time of conversion. Only conversion to whole life on a premium paying or paid up basis is allowed.

4. The inside buildup of the cash value is tax-deferred for FIT purposes.

5. The plan is available on a fixed premium basis with or without dividends or a universal life basis, or both, depending on the company.

The accident endowment plan is an example of complete coverage psychology but not complete coverage in fact. Its justification depends primarily on its role as the first meaningful step on the road toward the unavoidable necessity of total coverage.

Return to Work Benefit

In the arena of disability income benefits the trend toward complete coverage is alive and well. One interesting concept - the return to work benefit - might appear to some to extend coverage beyond reasonable limits in order to provide as complete a program as possible. However, many carriers should find it a useful device in moderating their loss ratios. The return to work benefit is a rider to a disability income plan, group or individual, which provides benefits similar to the following:

Months Disabled before Returning to Work	Number of Additional Monthly Payments
At least 12	2
15	3
18	4
20	5
22	6
24	7
26	8
28	9
30	10
32	11
34	12
36	13

For example, an insured who returns to work after at least 20 months of disability (including the waiting period) will continue to receive his monthly disability payment for five extra months while working on the job. This incentive to resume employment is intended to offset the psychological and financial difficulties in readjusting to the former status at a time when cash or liquid assets are at a low point for the insured. The cost for this benefit depends on the difference between the greater benefits provided and the more favorable experience expected under the rider, but it should not be made very expensive to be attractive to the insured. The effect of the rider in moderating unfavorable experience is greatest with plans providing the longest periods of coverage. The rider should be most effective in conjunction with a rehabilitation program to enhance the potential for recovery. Commutation of all or a number of payments may enhance the rider's appeal. As an example of total coverage, the return to work benefit is comparable

to covering at least one visit to the doctor for an annual checkup under a medical plan. Both benefits are intended to avoid expensive claims by including "redundant" coverage in the program.

Health Care of the Future

In spite of herculean efforts to bring medical costs under control to some degree, nothing has worked as well as initially expected. Most experts have no really new suggestions to make. The problem is that physicians are fully responsible for the health and condition of their patients, but turn out not to be fully responsible for the costs incurred in performing their function. In fact, no one or no one element in the situation is fully responsible. However, the health insurance contract, by specifying what is covered and what is not, has implicitly shifted part of the responsibility for medical costs to the insurance industry. The industry has become an unwilling and unwitting participant in the sky-rocketing costs of health care. To mitigate anti-selection by doctor and patient, coverage has been broadened over the years in accord with the prevailing trend toward total coverage; various cost containment programs have been in place for several years.

Where do we go from here? The next big step in health insurance will free doctors from the constraints of current policy language while simultaneously subjecting them to more realistic measures of effectiveness. The PPO, due to its concern with financial reality, is the organization to make this step initially. HMO's are less attractive because an arms-length distance may not necessarily prevail between providers, administrators, and investors.

More complete responsibility for medical costs is possible by granting physicians complete freedom in prescribing treatment according to professional standards. Consider a PPO operating under the following conditions:

1. All treatments prescribed by any licensed physician belonging to the PPO are covered by the carrier if they are within the physician's area of professional specialty, are not experimental in nature, and are not for the physician himself or his relatives. No reimbursements for medical treatments can be made by the insurer unless a physician's signature validates the claim. Peer review is resorted to in determining the reasonableness of questionable treatments. Second opinions are mandatory for highly expensive procedures.

2. Realistic deductibles and coinsurance apply to the benefit program. A separate deductible should apply to prescription drugs. For physicians in their first one or two years with the carrier, an aggregate limitation on covered charges for all patients, plus a limitation on the covered charges per individual patient will apply. These limitations may be removed or increased after satisfactory ratings are obtained by the physician.

3. Each physician in the PPO is subject to peer review, rating according to patient satisfaction, self-rating, and rating of professional effectiveness by organizations specializing in this function. Physicians not meeting the minimum standards can be excluded from the insurance program by the insurer. All carrier records are maintained on a physician basis in addition to other bases. The physician ratings are made available by policy provision to PPO subscribers and specified consumer organizations.

4. The insurer calculates premiums for subscribers to the PPO in the usual fashion. Rerating occurs annually or at six-month intervals. The risk charge reflects the potential for adverse claim levels as usual. Profit begins to emerge when actual experience compares favorably with expected.

Through extending the idea of total coverage to its logical extreme, the health insurance industry will return the health cost spotlight to its original subject, the physician. Before health insurance existed in any form, the physician decided uniquely his charges and his prescribed treatments for all patients. This is the way it should be at present. Modulating the fluctuations in costs for subscribers can provide commercial insurers a legitimate role in the health care arena. The role should not include defining or shaping the nature of the doctor-patient relationship, implicitly or explicitly.

II. THE COMPUTER VERSUS THE COMMISSION

The good old days of the prior century are long gone where insurance agents were provided a little training, a rate manual, and a commission agreement and actually expected to support themselves. Agent compensation based on a fixed percentage of premium, although primitive, was justifiable in that era considering that almost all agency expenses were covered by the commission payment.

Today, we are approaching the end of the commission concept as a proper method of compensation. The basic reason is that the activities traditionally expected of agents besides direct selling are being transformed into employee-related responsibilities. Additionally, the mechanization and computerization of the home office has had the effect of changing agency branch offices into simple extensions of the home office. What has been and can be accomplished by computer will not and should not be reimbursed on a commission basis.

Because of these changes, the fundamental trend is toward separation of agents into three mutually exclusive categories: true company employees, professional brokers, and agents owning carriers. Agents functioning as company employees will be compensated according to their quantitative work product only. Differences in type of coverage or amount of coverage will not override considerations of actual work performed in acquiring and conserving clients. Only dedicated company employees will be trusted to use the highly expensive computer, communications and other equipment permanently installed in branch or home offices. Proven loyalty will be a primary consideration in permitting access to sensitive or confidential records.

On the other hand, professional brokers will continue to gain ground with the industry and the public as they claim only to be interested in client welfare. However, the real success of the industry depends on the success of the companies comprising it, not on brokerage activities. The trend toward more highly organized brokerage associations will continue up to the point where brokers may be able to enforce a union concept in relations with individual companies. In other words, only one contract would apply between the brokers' union and the carriers comprising the industry.

As the difference between agents as employees and agents as brokers becomes more pronounced, companies will begin to separate the business generated by each to study the experience and underlying characteristics of both types. Brokerage business, due to the fact that it is normally a result of extensive shopping, should emerge as objectively inferior in most respects. As a result, the industry may eventually be adjusting brokerage compensation to reflect actual costs incurred. Rather than a decreasing or level

scale, the brokerage scale may be negatively sloped, so that the first year payment ranks as the lowest, the fifth year the highest, and succeeding years fall to about the third year level. Lower quality business is presumed here until proven otherwise. Most companies will not be paying standard' commissions for what is shown to be bad business.

The agent-owned insurance company is an interesting concept, but in practice should amount to little. Companies operated primarily for the benefit of only one group other than policyholders are unstable. They will tend to be sold more readily or quickly under unfavorable conditions than traditional ownership types; they will also be prey to the influence of current fads and wild ideas rather than long-term objectives.

Despite the claims of consumerists, the health of the insurance industry depends more on the health of the major insurance companies and their capacity to accumulate funds than on any other factor. Computerization is to the advantage of both company and client; the commission system has no ultimate need to exist.

III. INDEMNITY CONTRACTS

The long-term trend is away from indemnity payments and toward reimbursement determined by actual losses. The classic indemnity benefit - AD & D coverage - where specified sums are payable for the loss of an eye, hand, foot, etc., plus a specified amount for accidental death, is a good example of coverage rapidly becoming obsolete as medical technology has enabled doctors to reattach severed limbs successfully. Specified amounts payable after specified events (such as a hospital stay) have occurred are inherently anti-selective and also cost more to administer than reimbursement plans per dollar of claim payout. As a result, indemnity plans will be succumbing to competition from plans covering actual payout.

The L & H insurance industry will be appreciating that an ounce of prevention is worth a pound of cure more fully in the future. The safety programs P & C companies have instituted over the years are analogous to the types of expenditures L & H companies are and will be covering to influence aggregate claim payout. The dynamic social and economic conditions of the present and future preclude an indemnity philosophy based on actuarial or statistical reasoning only. Adequate, credible statistics are hard to come by in a rapidly changing environment. For example, requiring annual checkups and other preventive measures as a precondition to obtaining and continuing health coverage is quite possible for group coverage in the future, especially where the employer pays a large part of the monthly premium. Simply paying a premium cannot guarantee coverage; full cooperation will be expected with the real objectives of the coverage.

IV. GROUP ORIENTATION

The ordinary line of insurance is approaching maturity in the U.S. and should not be expected to grow substantially in terms of numbers of policies in the future. The total in force in the United States should stabilize near 150,000,000 policies and begin to decline slowly after 2000 A.D. in much the same way industrial policies have declined after reaching their apex in the Forties and Fifties.

No matter what they are called, insurance products of the future will tend toward a group orientation for the following reasons:

1. Regulation - less restrictive regulation applies to products legally qualifying as group coverage.

2. Economies of Operation - group can be less expensive to sell and service than ordinary.

3. Flexibility - policy language and premium levels can be more easily modified at the initiative of the carrier.

4. Soundness of Rates - simplicity of coverage enables actuarial soundness to be more easily demonstrated.

For this purpose, coverage is group oriented if a. master policy and certificates are issued rather than individual policies. Methods of distribution and marketing are not pertinent. As group products continue to expand and develop they will tend to assimilate the most attractive features of ordinary products so that the difference to the consumer will be nominal. In fact, group insurance will ultimately assume the dominating position held by ordinary; self-insurance in its various forms will occupy the place currently held by group insurance, and ordinary will find itself in the analogous position of the industrial line. The flexibility of ordinary products such as universal life indicates that group considerations are prevailing.

Over the years, the ordinary line has developed rates for certain benefits which, though reasonable and perhaps prudent, cannot be considered actuarially sound in the technical sense. For example, joint life policies and the joint life options for annuities and death proceeds are not based on actual joint life experience; the actuary combines single life experience together in a reasonable manner to obtain joint life functions, since true joint life experience is very sparse or non-existent. Sound rates are possible after credible experience has accumulated with reasonable or prudent rates. Unfortunately, it is considered impractical to accumulate joint life experience because of its two-dimensional aspect. Also, the joint life status his much potential for fraud and deceit. Since neither the group nor the ordinary line can resolve the joint life problem, joint life benefits will probably be declining in availability after 2000 A.D.

Another example can be taken with substandard insurance. Substandard lives are routinely issued standard ordinary policies at substandard rates. What is wrong? Actually, there is no basis for presuming that the extra risk for a substandard insured is relatively independent of the particular plan issued, e.g., single premium, whole life or term. Real substandard experience under the particular plan chosen by the risk is either sparse or non-existent. The group line would simply provide a special policy for substandard lives with benefits tailored to the substandard rating multiple. The customary re-rating process would automatically lead to a sound premium scale.

As a third example, many companies, especially stock companies, attempt to sell coverage at rates which are obviously below what current mortality, morbidity, etc., experience would indicate in order to gain a more favorable market position. In effect, they are simply gambling with stockholders' or policyholders' funds. Experience studies are highly unlikely to be conducted for these rates and policies, even though some idea of the character of the situation could be gained by reference to published studies by even the smallest companies. The freedom to engage in unfair price competition of this nature should ultimately be restricted after the turn of the century. The new Actuarial Standards Board indicates the direction the

actuarial profession must be taking. More rigorous standards for permissible rating methodology loom over the horizon. Any policy or coverage 'where credible experience does not emerge after five to ten years may be subject to cancellation at the option of the company itself or its competitors. Of course, policyholders terminated in this way should always be permitted to convert to a standard form of the same or a different company.

Insurance fundamentally requires a homogeneous group of real insureds subject to a known hazard of a demonstrably stochastic nature. Where these conditions are not satisfiable in principle or practice the insurance trans-action is inherently flawed. Stricter adherence to the technical definition of insurance in actual practice is the wave of the future, not relinquishing responsibility for contract obligations to federal or state government. Standardized benefit packages or programs have the best potential for developing credible experience. The ordinary line suffers from a plethora of distinctive benefits and features at frozen rates. Intercompany studies will be saving the industry, particular companies and the actuarial profession from much unwanted embarrassment. Experience studies conducted by government agencies will also assume much more importance in the future. However, each company will bear individual responsibility for the accumulation and analysis of its own experience regardless of volume.

V. COST DISCLOSURE

The long-term trend is toward more comprehensive disclosure of both the anticipated and actual cost of insurance coverage. For life insurance, progressive companies will be leading the industry in resolving the net cost calculation into two components rather than one. The first component, the protection element of the gross premium, will be compared to standard indices or benchmarks for any age or term of coverage. The second component, the savings element, will be subject to a return on investment, or yield, computation identical to standard methods for obtaining yields on any investment. The gross premium will be divided for this purpose in accordance with generally accepted accounting and actuarial principles.

Up till now, the life insurance industry has promulgated one cost index rather than two for comparing policies. Important disadvantages of one unique number are as follows:

1. The index is unique to life insurance and so does not apply to other types of coverage.

2. Supplemental benefits and riders to the base plan are not normally included in the index. Costs for the total life insurance program may not be available.

3. The index is difficult, if not impossible, for the general public to comprehend.

Resolving the life insurance cost problem into two measurements, both of which are readily comprehendible by the public is part of the general trend toward more complete disclosure of data relating to the insurance contract and company objectives. The companies which "have no secrets" are the ones which the public will prefer and regulators will give the benefit of the doubt to.

Part III

This series concludes with a number of practical suggestions for improving the status and prestige of the L&H insurance industry during the Nineties and beyond. The drop in public confidence during the

Eighties can be mitigated and ultimately reversed through common-sense measures enhancing regulatory and public relations.

I. OPEN AN ACLI BID OFFICE

The strength of the L&H insurance industry in this country has resulted from several practices not legally required in addition to the stringent legal standards prevailing throughout most of the industry's history. One of these practices--the custom of strong companies buying out insolvent ones--should be better known and appreciated by consumer advocates, legislators and the general public. The regulatory implications could be enormous if this custom were to be systematized and publicized.

Consider the following scenario: The treasurer and president of a small L&H insurance company are conferring with the Commissioner and Chief Examiner of their domiciliary state insurance department. Rather than continuing a fruitless search for more capital to avoid statutory insolvency, the group consensus is to initiate the ACLI bid process. The Chief Examiner promptly telephones the NAIC headquarters to put the company on the list of bid re-quests and writes a memo documenting the action for the Commissioner and a possible news release. The NAIC Bid Staff assemble the financial statements and other material needed for forwarding to the ACLI Bid Office. This Office functions as a clearing house for bids and bid requests arising from both the NAIC and industry sources. Any NAIC bid request is given priority over others; in addition, a list of companies has been compiled which will volunteer to make bids on insolvent companies if no bids are forthcoming otherwise. These companies are appealed to according to a predetermined round-robin procedure which takes into account their pre-specified limits of participation in the program. Generally, the larger the company, the greater the interest in dealing with insolvencies.

Four months later, the small L&H Company has been acquired for a nominal bid of $100,000 (estimated value of furniture, fixtures and equipment) by one of the companies on the ACLI list. Considerable liquidation costs have been avoided and all policyholders have maintained continuity of coverage; however, some will be facing revision in rates or policy provisions, or both, from the new company.

II. REQUIRE DEPARTMENTS TO FOCUS ON INSOLVENCIES

State Insurance Departments must examine carriers at least once every three to six years according to existing statutes. Since the end of World War II the number of L&H carriers has nearly quadrupled (not counting entities such as HMO's and PPO's). However, the number of qualified Examiners has not nearly quadrupled over the same time period. Existing statutes should be modified to either permit or require Departments to interrupt the normal sequence of examinations whenever a serious insolvency is discovered. Return to the normal examination sequence would be expected only when insolvencies are properly disposed of. The industry and the general public deserve a prompt response to ailing companies even though many healthy companies may not be examined for a decade or more. An NAIC Model Bill would be useful here.

III. EMPHASIZE CERTIFICATIONS

The first page of the statutory statement of any insurer contains a sworn statement by the top three officers and witnessed by a Notary Public as to the correctness of the document. Rather than relying

solely upon a CPA's opinion of an insurer's financial condition, insurance regulators implicitly remind the industry of its fiduciary aspect by legally binding the three top officers in the event of errors or deficiencies. Very few, if any, industries are subject to this regulatory requirement and few people either inside or outside the insurance industry comprehend its significance. The fact is that the ultimate concept of insurance boils down to the certification principle. Sworn statements, legally binding contracts, professional or expert opinions, etc., and all supporting data are simply variations on the underlying certification theme and must be regarded as no better than the persons responsible for them. The quality of insurance is simply a function of the quality of people behind the insurance.

This primordial idea assumes some importance when regulators and regulations (both state and federal) impose burdensome reporting requirements which soak up innumerable man-hours and increase operating costs significantly. The truth is that a properly executed certification with perhaps substantial financial and/or other penalties for noncompliance or failure to perform satisfactorily is the best course for responsible insurers to pursue in complying with the maze of state and federal regulation, especially where oddities, uncertain interpretation, or probable revisions are involved. The greater the number of persons signing a legally binding certification, the greater its value in avoiding unnecessary or costly regulations. Certifications of the future will probably be complex documents with space for up to a dozen or more signatures in some instances. The fiduciary aspect of insurance will be most perfectly served and preserved in this manner.

IV. PROMULGATE AWARDS CEREMONIES

Back in the days when the business of America was business, awards ceremonies were uncommon and not highly publicized. The opposite is true today. Sports, Entertainment, the Arts, Science, and the Media each promulgate their characteristic awards, spending millions in the process to achieve full exposure. The insurance industry and American business generally have not kept pace with the awards phenomena, except perhaps with the sales function to some extent. The social prestige of business relative to other areas in society has been slowly declining; as a result, attracting the best talent and maintaining a positive public image is becoming more and more difficult.

If highly-publicized awards ceremonies have increased the prestige of the sports and entertainment fields, why wouldn't the same practice improve the public image of insurance and business generally? The subjective nature of these awards is not an impediment to their effectiveness in spotlighting both the recipients and the donor. Both parties benefit where publicity is involved. Also, there is no need for concern that awards bear some logical relationship to each other. Redundancies, discontinuities or inconsistencies in how awards are made or who makes them are unimportant compared to the essential thought behind the awards themselves. For general business awards the best vehicle would be the local and national Chambers of Commerce. Trade Associations can promulgate awards for particular industries. Company awards can also contribute tremendously to elevating the public image of business and the insurance industry.

V. ORGANIZE AN INSURANCE INSTITUTE FOR PROFESSIONAL EXCELLENCE

The comprehensive examination programs sponsored by a handful of professional organizations within the industry constitute another practice not legally required, but serving to strengthen and promulgate higher standards within the industry. However, little or no recognition or appreciation of these

examinations extends beyond the insurance industry itself. The examination tradition in academia receives unequivocal respect from the general public. The insurance industry deserves a higher profile among both academics and the public for its examination programs and the intellectual integrity they represent. What any one professional organization might find too difficult may be possible if these organizations presented a united front.

The "Insurance Institute for Professional Excellence" is proposed as a service organization devoted to increasing public awareness of and confidence in insurance professionalism. It would be composed primarily of members of organizations giving examinations and function as a coordinating committee to optimize efficiency and effectiveness in insurance examinations. If insurance exams possess no significance among academics, why not? How can all professional insurance exams be presented and organized so as to gain complete credibility with the public, legislators, academia and other professionals? A chain is presumably no stronger than its weakest link. Full credibility for actuaries, for example, may be virtually impossible if the examination programs for other insurance professionals possess little or no credibility.