

SUITABILITY ISSUES IN INSURANCE

*Evaluating Suitable Coverage for
Today's Clients*

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COMMONWEALTH
SCHOOLS
of Insurance

P.O. Box 22414

Louisville, KY 40252-0414

Telephone: 502.425.5987

Fax: 502-429-0755

Web Site: www.commonwealthschools.com

Email: info@commonwealthschools.com

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Suitability Conduct

In the world of insurance, client's must decide when to insure, what to insure and how much to cover and pay. As an agent, it is your job to analyze these needs and be an advocate or problem solver to make sure the requested risk has been transferred. A client views policies in terms of obtaining reduced uncertainty. In most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in solving client needs.

The greater agent due care exercised, the more valuable the service. There are a variety of techniques that are accepted and used to determine customer needs or suitability. Some are more traditional than others. Most are seen as solutions to identify a certain customer segment. They give logical, rational explanations about where the customer fits in but do not explain how the customer feels and cares. Policy applications are an example of information an agent might use to identify who he is about to insure.

Suitability Duties

It may not be your legal duty to secure complete insurance protection against every conceivable need an insured might have, but there is definite legal obligation to explain policy options that are widely available at a reasonable cost. Likewise, an agent has a legal duty to use reasonable skill in asking certain questions during the application process to determine types of coverage needed. Further, failing to determine the nature and extent of the coverage requested may subject you to a lawsuit.

For a majority of suitability lawsuits, the basis of liability is relationship and purpose. Legally a personal relationship is created when a prospective insured consults an insurance agent, provides that agent with specific information about his unique circumstances and relies on the agent to obtain appropriate coverage tailored to these circumstances. Courts have recognized that the relationship between a prospective insured and an insurance agent (like the relationship of attorney and client) is that of principal and agent, for the purpose of negotiating a policy suitable to the client's needs.

An insurance agent owes the prospective insured a duty of unwavering loyalty similar to that owed by an attorney to a client. It is the special fiduciary nature of the relationship between a prospective insured and an insurer that lends the relationship a personal character similar in scope to the lawyer-client relationship. For this reason, alleged acts of negligence on the part of an insurance agent who has been consulted for the express purpose of meeting a client's unique needs create a personal tort.

For example, cases have looked to whether the insured's made express representations to the agent about the importance of arranging a set of policies that would prevent a gap in coverage. The insured's relied on these agents to obtain the appropriate coverage, and the agents failed to use reasonable care, skill and diligence to procure suitable policies. The allegations in the complaints make clear that the insured's expected the agents to respond to the couple's unique, personal insurance needs. A \$600,000 claim proved that a gap in coverage existed and therefore it was not a suitable policy.

In another example, the agent had specialized in the sale of what is referred to as bank financed insurance or insurance under the bank loan plan. The plan was that premiums would be provided by borrowing the amounts thereof from a bank and securing the bank by assignment of old and new policies. The court discussed the issue that a bank finance plan could be useful for a person whose

income and financial condition is such that his income tax puts him in high brackets and who has the means to liquidate the steadily increasing debt out of other sources.

Did this make the agent guilty of a breach of duty in a failure to make disclosure of certain facts? Was this product suitable? What about the rather large commissions, not ordinarily possible with a client in this income category?

The trial began by with a citation from another case, where the agent's license was suspended for making false and fraudulent representations in selling bank financed life insurance. There the court said, "The appellant was an experienced expert in the field; the insured a mere layman who was led to believe that the bank plan would meet certain expressed objectives. Certainly the relationship was a fiduciary one in which the plaintiffs were entitled to believe the agent's material statements."

In this case, the court determined that the insured did rely upon the agent's statements and that it would be unreasonable to argue that the insured should have found out for himself, because of some principle of caveat emptor, that the program was not at all what it was represented to be.

The insured testified, "I had my faith in him because he was recommended by a leading business man. I figured he knew what he was talking about. He had all the facts in my case. I figured he was giving me something that was designed for me."

It was also uncovered at trial that the insured inquired about reducing or dropping the program after starting it, in case he could not afford it. The agent assured the insured he could cancel. What the agent neglected to say was that cancellation would result in a substantial loss to the insured.

Insurance experts were brought in on both sides of the argument to prove or disprove suitability. Both experts, for the plaintiff and for the defendant, agreed what would constitute a suitable insurance plan for the insured and what factors to consider:

- The details of the existing insurance program
- Its values and benefits
- The cost of continuing the old program
- The additional cash outlay for the new program
- Loss of values and benefits, if any, under the old program
- The additional values and benefits of the new program

The court held that one, who undertakes to make statements under circumstances such as this, is bound not only to state truly, what he tells, but also not to suppress or conceal any facts within in his knowledge, which materially qualify those statements. If he speaks at all he must make a full and fair disclosure. This is particularly true where one party to a deal, though in no sense a fiduciary, is possessed of superior knowledge as to facts material and important to the transaction which he fails to disclose to the other party.

Meaning of Suitability Conduct

Beyond being the most responsible agent you can be, you should size-up your client and anticipate his needs when he cannot. How can this be accomplished?

Aside from determining current and future risks that you know about, you need to expect those that have not happened. For instance, you should know that a 50-year-old baby boomer client is a far more complex individual than his parents before him are. His insurance needs are also more complex: higher life limits to cover college and entrepreneurial pursuits; medical coverage's, long-term care and more retirement needs for a longer life span; higher primary and umbrella coverage has to protect against lawsuits.

To really uncover as many of these client needs as possible, you must know more about your clients. Of course, a client profile is the best way to accomplish this. Customer profiles can provide a lot more information than you would glean from an application. You must also ask clients what about their needs. Three important questions might be:

- Have I given you all the information you need to make a decision?
- Does this information or policy make sense?
- Is there something else I can answer for you to assure you that this is the right solution based on your needs and objectives?

In addition, you should do research about their needs as a group so you can better anticipate insurance needs. Every additional bit of information you learn about your client helps you get closer to knowing their goals, needs, and wants.

In some cases, your clients will not know the answers to your questions themselves – you may need to interpret for them. But, by all means never do this without involving them in the process. And, of course, once you have asked all the questions you must be sure that you implement or meet their needs to the best of your ability.

Risk

Before you can determine what is suitable or not, you need to discover the purpose behind your work. You are your client's unofficial risk manager. This means you help identify the everyday risks they are exposed to and recommend ways to transfer it, avoid it or reduce it.

Risk is a fact of life to be constantly analyzed and managed. There are many ways a client can suffer major financial setbacks in the face of an unexpected injury or natural disaster. Further, there are many more legal ways that others can to get to your clients due to expanding liability theories in our courts and the trend to pursue "deep pockets".

Unfortunately, the time most people devote to managing their own risk is typically less than the time they spend planning a summer vacation. As important as it is to assess your client's risk issues, not everything can be covered and there are times you will not be able to provide any coverage at all. These are facts that all clients need to know before you can help them.

Identifying Client Risks

The process of identifying client risks is not as complicated as some make it to be. Clients fill out forms and insurance applications which help quantify and qualify the coverage is needed.

What a client does for a living, his age, where he lives and even his recreation determines the many risks that your clients are exposed to. Family relationships and responsibilities create additional risks

as do what is owned and owed. A client's concern for family members he might leave behind is yet another risk determinant.

How are client risks discovered? Through insurance applications and/or forms you create. There are so many possibilities and options that it is impossible to present you with a single format. Adapting existing policy applications is probably a good start. When completely filled out, you will see areas of concern and potential exposure probably not mentioned in a verbal interview.

The Importance of Applications

Proper attention to the completion and submission of client applications cannot be stressed enough. Not only is there valuable risk information, but mistakes by you or a client can void, decline or reduce coverage. Be accurate, timely and explain to clients the serious nature of misrepresenting any information they provide.

Once you and your client have identified their risk exposures, you need to determine a strategy to handle it. Consider the following options: A client with an identified risk can either control it or finance it. Controlling client risks involves avoiding or reducing them:

Avoiding Risks

The tools to accomplish this are in the decision not to own something, not to do something, not to say something or just to not do something that could create or represent risk exposure.

Reducing risk involves the issues of loss control with a focus on safety, procedures, pooling, segregation, and diversification. Financing risks involve transferring, sharing or retaining them. Transferring or sharing risk can mean renting instead of owning, buying insurance, using credit instead of assets, or getting hold harmless agreements. Retaining risk examples include insurance deductibles, co-insurance, self-insurance or simply ignoring the risk and absorbing the full cost if it occurs.

Needs-Based Analysis

Beyond the issue of risk, traditional industry thinking tells us that suitability should be based on needs. Needs analysis is a procedure to help prospective insurance clients plan for their future.

Needs-based analysis has been around since the early days but it was refined in the late 1960's by Thomas J. Wolff, a tenacious and studious insurance agent, who is today an industry legend. As a young agent, Wolff struggled to make it in the business.

While other agents and teachers dazzled their audiences with tales of sales wizardry and artful cherry picking among the rich and famous, Tom Wolff told a much different tale. Instead of trying to achieve his place by showing everyone how good he was, he taught his students how effective they could be as agents through capital needs analysis and financial needs analysis. Thus began the beginning of the suitability approach to selling insurance.

The purpose of a needs-driven sales system is to analyze a client's needs and determine how insurance can best meet those needs. It is not meant to generate the sale based upon the obvious

points of the product or the need of the salesperson to produce. It uncovers a prospect's general financial problems or deficiencies so that the prospect begins to recognize the need.

The problem is personalized to arouse interest in a possible solution. Like any system, needs analysis works effectively only when it is used as it is designed. The system builds upon itself in terms of both content and data and is most effective when used from start to finish. Shortcuts undermine the effectiveness of the process. An agent following this system from start to finish should never be accused of less than professional point-of sale practices.

Needs-based analysis goes into great detail in analyzing needs and creating recommendations that are based upon airtight logic and conclusions. Needs-based selling involves the client, allowing him or her to use his or her own ideas and assumptions. It is a process that allows the prospect to participate in creating his or her own solutions to needs based upon what he or she considers important. Analyses must represent and respect the client's opinions. The goals are those of the prospect, not the agent. If the goals are not the goals of the prospect, the prospect is not likely to go along with the agent's recommendations in the end.

Needs Based Selling?

The focus of needs based sales training is to teach techniques to uncover prospects' specific needs before features and benefits of the product or service are discussed. Needs analysis helps the agent sell the right amount of insurance to the client for the right reasons. This is much better than simply selling product and ethically more correct than convincing a prospect that the product you have is what they want.

The analysis is characterized by the recognition of accurately assessed needs, which is the result of careful and professional analysis. Through careful fact-finding, information is gathered about the prospect's desire to provide income to family members in the event of premature death or disability, plan for retirement needs and accumulation and/or cover unexpected loss of property. The analysis performed is based upon a myriad of things: interest rates, inflation assumptions, salvage value and the prospect's views about his or her objectives and timetables.

Needs analysis helps the agent sell the right amount of insurance to the client for the right reasons. In today's competitive environment, agents cannot afford the exposure of makeshift or piecemeal sales practices. They must provide a needs-based analysis for their clients and generate trustworthy recommendations based on this investigation. Learning how to effectively determine needs gives the opportunity to offer a full array of financial products and services.

A Complete System

Needs-based selling is a complete system for obtaining the appointment, opening the interview and gathering factual data for all types of prospects. At the end of the fact-finding process, a joint decision is made between the prospect and the agent as to which of three cornerstones of financial security is top priority:

- Accumulation (developing a sound plan to assist in paying for education and for other financial objectives)
- Retirement (planning to provide the additional income needed to supplement Social Security, pension plans, existing savings and investments)

- Protection (planning to assure that obligations are met in the event of death, disability or loss of property).

Let us assume a life analysis was being conducted for a baby boomer client. Your fact-finding will likely reveal that most boomers are underinsured and require more capital in the event of death than other segments because they have large loans, college-bound teens, business income replacement, partner buyouts, spouse retirement needs, etc. Seniors, on the hand, are “winding down” their lives with fewer protection needs. However, for those who have not planned as well, an in-force policy that can be sold as a life settlement to pay long term care costs or small burial plan can be a real comfort.

Performing Needs Analysis

The needs analysis system breaks the sales process down into carefully engineered parts:

The Pre-approach

This step is designed to get an appointment under favorable conditions for a face-to-face meeting.

The Approach

The objective of the approach is to obtain the appointment. During the approach, no detailed data-taking or selling takes place.

The Initial Interview

The agent’s objective during this initial interview is to gather information and uncover the dominant needs of a prospect. Information such as name, birth date, spouse’s and children’s names and birth dates, address and telephone numbers, property owned and basic obligations are gathered at this time.

Other information to obtain at this time is occupation, spouse’s occupation and whether or not the prospect is a smoker, works at home or engages in a high-risk occupation or hobby. A questionnaire is usually filled out at this point, rating his or her feelings, concerns and goals in a variety of areas.

Next, the prospect’s financial situation must be assessed. This part of the questionnaire covers such areas as annual income, total life insurance, total assets and total liabilities, the value and the mortgage of the residence, and present investments (such as savings and CDs, money markets, mutual funds, real estate other than the residence, stocks and bonds, U.S. government bonds, IRAs, 401(k)s or other salary savings plans, and pension or profit sharing plans).

The questionnaire then assesses the prospect’s financial risk profile. For example, what kind of financial risk is he willing or able to take? Considerable risk? Almost none? Is he willing to take average risks in order to improve the rate of return? Is he or she willing to take substantial risks in order to maximize the rate of return?

In the next part of the questionnaire, the prospect is asked to make expectations and predictions about his future. For example, will he be changing jobs, starting a business, selling a business, receiving a promotion or retiring, buying a new home or car? Will he be buying a larger or smaller home, making improvements to a home, caring for a parent / spouse or changing marital status?

Does he anticipate getting a raise, getting a bonus, inheriting assets, borrowing money, paying off a loan or purchasing property?

This initial interview begins the process of building trust. The initial interview and questionnaire allow the agent to screen the prospect and then determine whether to eliminate him or her based on the data gathered or to proceed with the selling process. The data gathering phase of needs analysis is designed to help understand people. It is often said that people don't buy because they are made to understand; rather they buy when they feel they are understood. The more time that is spent in the effective gathering of both facts and feelings, the less time that will be needed to be spent on the close. Being sincerely interested in people will permit them to be openly interested in the full presentation.

The Review

After the prospect completes the questionnaire, the agent reviews it quickly and looks for areas of importance. The agent may discover, for example, that the prospect is not satisfied with his current premiums, the percentage of income he or she is saving, that he or she does not have an understanding of trusts or that he or she does not participate in a pension or profit sharing plan.

The relationship should be terminated if the prospect is uncooperative, if his or her needs do not meet the agent's minimum requirements, area of knowledge or if insurability does not permit the agent to offer help.

The interview should be continued if the prospect agrees that this is an appropriate time to engage in further discussion, or another appointment should be scheduled. An appropriate prelude to further discussion might be advising the prospect that the 15 minutes are up, and that the agent is prepared to leave as promised. The agent may suggest that, based on the information shared, he or she can be of assistance to the prospect in the areas where the prospect's goals are not being met. The purpose of this interview is to screen the prospect and uncover his or her needs. Naturally, some cases are more involved than others, and the agent may experience a situation where he or she feels overwhelmed and in over his or her head.

At this time, it is wise to make the decision to involve a manager, trainer or a fellow agent with expertise in the advanced market areas. Even if this means splitting a commission, the agent will benefit by learning more, earning more and developing a loyal client, not just a policyholder.

Matching Client Needs with Product

When you are comfortable that you know your client needs and have asked the client himself, it's time to match these needs with an appropriate product. Much has been written on the perils of matching the wrong product to a perceived client need. This is an area where agents need to exercise extra due care for the client's sake and their own financial well-being.

Questionable market conduct in the 1980's and 1990's created new demands for today's agent. Past agent abuses have centered around twisting, wholesale replacement, deceptive advertising, misleading illustrations and other unethical acts.

Regulators have responded with replacement policy forms, insurer fines, agent reprimands, and in some cases, revocation of licenses. To compound the problem, the industry's image has been

occasionally tarnished by solvency problems. Further, stiffer competition, declining interest rates and thinner profit margins have impacted how insurers and agents work together - less support in marketing and support materials.

The bottom line in either case is that agents are forced to work harder and smarter. In lieu of sitting back and waiting for the market to improve, industry forecasters say that agents must accept new roles to survive.

Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell. The trend toward "agent as counselor" is the most obvious path. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag as you will see in this chapter.

Both regulators and clients will hold insurance professionals to ever higher standards. Agent due care and sales conduct will be more important than at any time in our industry's history. This will involve a commitment by agents to polish skills and acquire a systematic approach to filling client needs. Following are some basic due care discussions which may help the agent get started. Of course, every situation will vary and require constant refinement:

Life Insurance Risk Analysis

Before determining the amount of life insurance needed by a client, due care would involve the agent and client in a discussion concerning the various types of life insurance available: term, whole life, modified whole life, single premium whole life, universal life, variable life.

The attributes of these different policies are best left to a course on basic life insurance. However, it is critical, under due care, that agents recognize the pure risk need of clients and counsel them on the proper choice. For example, persuading a client to accept a high monthly premium whole life policy with a settlement payoff that leaves a significant financial gap at the death of a breadwinner, is not exercising due care.

This is not to imply that whole life forms of insurance are inappropriate. Rather, there are situations here a client's age and situation call for the agent to consider future estate settlement costs and liquidity as prime directives in making policy choices. There may even be conditions where due care by the agent might involve a recommendation for a client to carry little or no life insurance at all. Issues regarding life insurance needs for singles, non-working spouses and children are often debated among financial planners and agents alike.

One process for determining an estimate of the amount of life insurance needed is called capital needs analysis. Financial planning courses cover this process in considerable detail and typically include a sample capital needs worksheet. For purposes of proper sales conduct by agents, factors to consider by agents include:

Capital needs for family income Most families will be able to maintain their standard of living with about 75% of the former breadwinner's income. Depending on the skills and resources of the surviving spouse, this fund may be large enough to provide lifetime income or for a specified period of transition.

Capital needs for debt repayment Typical debts to consider include home mortgages, charge cards, bank notes, business debt, etc. A decision can be made to totally liquidate the debt or to use life insurance proceeds to set up a "sinking fund" to make payments for the life of the loan or a specified period.

Other Capital Needs This might include emergency reserve funds, estimated to be between 50 percent and 100 percent of a client's annual after-tax income, and possible college education funds for surviving children.

Estate Settlement Costs Final expenses can be expensive. Uninsured medical costs and funeral expenses are one aspect. In addition, there are federal and state death taxes. Although the Economic Recovery Tax Act of 1981 eliminates the federal estate tax on property passed to a surviving spouse, the estate of the survivor may face a large death tax liability. Further, there have been recent attempts by Congress to lower the exemption levels. State death taxes vary considerably.

Current Assets Available for Income Production What current assets, such as savings accounts, investments, real estate, pension plans, etc., are currently available for income production or liquidity needs to offset the capital needs above?

Net Capital Needs By combining the above factors, the agent can arrive at the net capital needed to be replaced by life insurance.

Where capital needs analysis indicate that a \$500,000 gap will occur at the death of the breadwinner(s), the agent's due care life insurance recommendation should be for \$500,000 of life insurance. Anything less could leave the client underinsured.

Lesser amounts may be purchased where the client cannot afford the premiums or makes the choice to carry less. If there are additional concerns, such as a client's long-term health, the agent might be advised to disclose his recommendation even though a more expensive policy with less coverage is purchased.

Ongoing monitoring of capital needs is necessary to plan for new client objectives, repositioning of debt, inflation, estate settlement changes and potential health problems that may prohibit coverage in the future.

Another due care consideration concerning life insurance is ownership or title of the policy. Agents should recognize conditions where it would be beneficial to keep life insurance proceeds out of a client's estate by using a life insurance trust or alternative ownership. Due care may be sufficient where agent disclosure of estate tax consequences of life insurance owned by a client and a proper referral to a competent estate planning attorney is pursued.

Essential Life Insurance Due Care Questions

- What existing death benefit sources does the client have? Group life, survivor's income, individual plans, association group life plans, pension plan death benefits.
- Who is insured? Is someone contributing economically who must be added?
- Do all death benefits, along with available assets, meet client objectives?
- Are there other needs to consider such as dependents with special problems? Business debts? Personal debts?

- Is there existing life policies that can be cash surrendered or tax exchanged to plans that are more efficient?
- Is waiver of premium available? Is this a desirable benefit for this client?
- Is there accidental death benefit or double indemnity? If so, is this desirable or can it be dropped in favor a lower premium?
- Is coverage guaranteed renewable? To what age? Is the client's health stable enough to change policies?
- Is coverage decreasing term? Is the balance sufficient?
- Is there a substandard rating that can be removed?
- Are there policy dividends? Is the client making the best use of these dividends? Or, would reduced premiums be recommended?
- What are the settlement options available at death? (Lump sum, payment options, insurance trust, etc.)
- Is there a plan for the "common disaster" involving both husband and wife?

Disability Insurance

Statistics have surfaced which indicate that the average person is three times more likely to suffer a lengthy disability than die. Providing a source of financial income in the event of a major disability is probably the most overlooked portion of client financial planning. By definition, a disability can be a temporary or permanent loss of earned income due to illness or accident.

Essential Disability Due Care Questions

- How much monthly protection is needed? Is an individual policy needed to supplement work plans?
- When does protection need to start? (30, 60, 90 days etc. -- the elimination period) Can the client "self-insure" for a period of time?
- Does the client have discretionary income to buy needed protection?
- Is the coverage non-cancellable or guaranteed renewable? Can a block of insured's, including your client, be canceled?
- If multiple policies are owned (employer, association, individual), will the benefits of one be reduced by the other? Is there a case for eliminating a policy?
- Is there an employer supported uninsured sick-pay plan available?
- What is the definition of a disability in the client's policy? How severe? How long?
- Does the policy include occupational and non-occupational coverage?
- Is there a substandard rating or waiver of condition? Will the company remove it? Will another company write without a waiver?
- Is there a waiver of premium benefit? Would this be necessary for the client?

Similar to life insurance, due care analysis by the agent involves "need analysis". Through inquiries and available financial papers the agent should determine the current after-tax income needs of the client. This amount could be reduced by expenses that might be eliminated due to the disability. For example, if the client is homebound, he will not need to cover transportation costs of commuting to work or other work related expenses.

Next, an adjustment for possible government benefits can be made using Maximum Benefit Amounts that might be available from Social Security. Minimum employment history and limitations on the term

of protection covered should also be considered. Other adjustments that an agent should investigate include earned income continuing from other family members, investment income that might be derived from current assets and inflation to keep pace with cost of living increases. For just about every client, the above process will establish that some form of disability protection is generally needed beyond the limits granted social security, and in some cases private, employer provided protection.

Once a disability need is established, it can be compared to the participation limits allowed by insurers and the ability of clients to afford it. Disability sales conduct would involve an agent/client discussion explaining how disability insurers may only offer certain maximum allowable coverage tied to income (a client who earned an after tax monthly income of \$7,500 might be eligible for a maximum of \$3,000 of monthly disability coverage).

There may also be limits of how long this protection is covered (24 months, five years, or to age 65). Further, there may be minimum waiting periods before coverage begins (90 days, 180 days).

In addition, there may be reductions in the amount of disability protection paid based on the degree of the disability (a partial disability that allows a client to continue working may reduce benefits substantially). Finally, watch for renewability features. Some policies are truly non-cancellable and guaranteed renewable. Others may appear to be renewable unless cancelled by "class".

Thus, if an insurer has a particularly bad block of business with a higher than normal claims experience, it can cancel that class of insured's. Clients need to be counseled that the gaps in coverage outlined by these events require them to seek alternative forms of protection, develop contingency plans or rely on available pension plans, family members and accumulated savings to make ends meet during times of disability.

Health Insurance

Health insurance is one of the most valuable segments of risk management and the most difficult to predict. This is further complicated by exploding medical care costs and the never-ending efforts to create a national health care system. Hours of agent due care to develop a long term plan for clients may be broadsided by an entirely different style of health care brought on by federal directives or outrageous premiums.

For this reason, health care planning is one form of insurance that is in constant review. The most efficient form of health protection is by group coverage. Group insurance is the predominant way of providing health insurance today with a definite trend toward HMOs (health maintenance organizations).

Due care in health counseling would involve fact finding to determine sources of social insurance available to the client such as Medicare and occupational worker's compensation. Any gaps in coverage need to be filled through blanket health coverage or medical benefits under a liability policy if the health condition developed as a result of an accident.

In addition, an agent-to-client discussion should cover points concerning:

Basic Eligibility

- Exactly who is covered?
- Does "family" include the subscriber, spouse, one, two or more children?
- How old can the children, be and still be covered?
- Does this change if the children are married?
- Will family members lose their eligibility when they turn 65 and Medicare takes over?
- How will a divorce affect a member's coverage?
- Will a foreign or out of state residency longer than six months affect coverage?
- How long will a retarded or physically handicapped child or member be covered?

Total Maximum Coverage

A limit to coverage could be present in form of duration and/or a dollar cap.

- Is this a "lifetime cap"?
- Is this cap per family member or for the entire family?
- A lifetime cap of between \$2 and \$5 million, per family member would not be uncommon and might be considered a minimum considering the high cost of medical care.

Deductibles

- How much is the deductible, if any exists?
- Is it per family member? Per year?
- Is there a maximum deductible per family?
- Are there specific deductibles for medicines vs. health care?
- Are there deductible surcharges if the client does not pre-register with the insurer, say for non-emergency care?

Stop Loss & Co-Payments

- After deductibles, is the client expected to share or copay any medical expenses?
- Is there an established time, usually after a specific amount of expenses have been incurred, that the co pay will stop and benefits will be 100% covered by the insurer?

Pre-Existing Conditions & Waivers

- Are certain known pre-existing health conditions prohibited or waived? If waived, for how long?
- Is there a waiting period for unknown pre-existing conditions? Some policies specify a 6 to 12 month waiting period for listed conditions such as: hernia, tonsils, adenoids, hemorrhoids, varicose veins, nasal surgeries, foot and toe surgeries, breast reductions, otitis media (ear problems), pregnancy, etc.

Exclusions

Possible policy exclusions or highly limited protection might include conditions and services as follows: medical costs exceeding limits, unlisted services, service covered by occupational insurance (worker's compensation, etc.), health problems due to acts of war, government provided services, Medicare benefits, services from relatives, private nursing fees, custodial care, long-term care, inpatient diagnostics (x-rays not related to specific surgery), dental and hearing aids, vision care, speech therapy, cosmetic sex changes, infertility, weight reduction, orthopedic devices, maternity care, outpatient drugs, acupuncture, nutritional counseling, physical or occupational therapy outside the hospital.

Some "bare bones" plans may cover costs only at prescribed hospitals, although emergencies are typically covered no matter where. Some only pay for procedures incurred in the hospital-by-hospital employed physicians (regular doctor visits or follow-up sessions are not covered unless specified by the hospital doctor). Further, many plans may cover certain hospital procedures but not the supplies (a blood transfusion procedure may be covered, but not the cost of blood).

One of the latest trends is the requirement that certain procedures, such as organ and tissue transplants, be pre-authorized. Additionally, some procedures are considered experimental and not covered under any conditions. Mental health and home health care are usually very limited areas of care. Dollar limits per day with annual maximums are not uncommon, as are maximum visits per year.

Guaranteed Renewability & Rate Changes

- Can the insurer modify or change premium costs? Under what conditions?
- Can a class or "block" of subscribers be changed without changing rates for all subscribers?
- Can the subscriber be canceled? If so, how long will benefits last if client is in the middle of a health crisis?

Important Dates & Notification

While many of the above exclusions and limitations are typically spelled out in policy brochures or in bold print, issues of important dates and notifications can "fall through the cracks". Proper due care would involve a discussion or memo to the client concerning policy time lines. Examples include:

- "All claims must be filed within 15 days on approved claim forms"
- "The insurer must be notified within 60 days of any newborn or adopted children"
- "Annual notice is required to sustain coverage for a retarded or handicapped child who is older than the specified age limits"
- "A family member must apply for his or her own plan within 31 days of the main subscriber's ineligibility"

Agents who handle multiple lines of insurance must consider the impact of health insurance on the client's financial planning. A medical catastrophe can permanently devastate a family. No one can argue the importance of life insurance, disability protection and certain property/casualty coverage, but health insurance is a clear priority. It would not be considered due care for an agent who handles

different product lines to market a costly \$250 per month whole life insurance plan to a financially limited client when there was no health insurance in place.

A more prudent approach would combine a "basic hospital plan" for major medical emergencies at \$150 per month and a term life plan for \$100 per month. Even the agent who specializes in a specific product line should exercise due care to inquire that clients have health coverage in place or at least budget for the same before selling other forms of insurance.

Essential Health Coverage due Care Questions

- What available sources of health care are available to your client: group plans (employer provided), HMO's, Medicare, other?
- Does your client have enough medical expense benefits to meet basic hospital needs or major medical expenses?
- What family members of the client require coverage and are they eligible? Does the client or family member need supplemental coverage?
- Should the client terminate any existing or duplicate medical expense premiums?
- Does the client have dependents who have or will soon terminate coverage under the family plan? If so, can they purchase their own?
- What conversion rights do they have?
- Is your client's policy guaranteed renewable?
- Does the client's health care continue to protect dependents in the event of his or her death?
- Does the client have a substandard rating or waiver of coverage? Will the insurer remove it? When? Will another company write without the waiver or rating?

Long Term Care Insurance

Long-term care is the kind of help your client needs if he is unable to care for himself because of a chronic illness or disability. Most long-term care policies and state regulations define a "chronically ill" individual as someone unable to perform at least two activities of daily living for a period of at least 90 days and/or someone who requires "substantial supervision" to protect themselves from threats to health and safety due to severe cognitive impairment.

Long-term care services can range from help with daily activities of living, such as bathing, shopping or dressing, to skilled nursing care in a nursing home. Care can be provided by friends and family, local home care agencies, adult day care programs, nursing homes, and residential and retirement facilities.

The traditional long-term care policy is defined as any accident and health insurance policy or rider advertised, marketed offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than acute care unit of a hospital.

The long term care continuum is the ever-expanding and multi-faceted range of services needed by the long term care market. Today's continuum might consist of the following:

- Chore services: Volunteers buy groceries; mow lawns, vacuum, run errands, etc.

- Home visitors: Meals-on-Wheels, story reading, companionship, etc.
- Senior centers: Social activities, dances, bus tours, etc.
- Adult day care: Daytime activities, lunches, therapy, games, etc.
- Home health care: In-home services by nurses, physical therapists and dieticians, etc.
- Rehabilitation programs: Provide extensive physical therapy, occupational therapy and speech therapy.
- Respite care: Individuals provide relief to aid primary caregivers.
- Retirement housing communities: For the independent elderly, offering individual units, security, social activities, etc.
- Continuing care communities and centers: Designed to meet residents' changing needs from retirement housing through skilled care.
- Assisted living centers: Offer medical attention, as well as assistance with eating, bathing and other activities of daily living.
- Nursing facilities / skilled nursing: Provide intensive nursing care around the clock.
- Sub-acute care: Provide post-acute or heavy skilled care that is expected to be of shorter duration than usual skilled care.
- Acute care: Surgical or hospital with lengths of stays limited by diagnosis-related insurance coverage.

The continuum is in a constant flux as it responds to new terms, new legislation, coverage limitations, medical breakthroughs and other market-driven demands.

Similarly, long term care policies, both old and new, must be placed in the context of continuum changes. Residential Care Facilities and Adult Day Care, for example, are increasingly covered in today's newer policies. Earlier policies restricted benefit payments to only those facilities that offered Adult Day Care, a much more restrictive definition.

Another example is policies that covered home care, but required that services were needed because the person would require institutional care without them. Agents need to understand how the policies they offer relate to Continuum of Care services in from the standpoint of policy triggers, ADLs, mental deterioration, etc. This can only be accomplished by evaluating individual policies and client needs.

Essential Long-Term Care Policy Questions

- Is the benefit amount enough to meet the cost of local nursing homes? Costs can range from \$90 in the mid-west to \$300 in New York City. Be sure to advise clients that costs may exceed benefits.
- Does the policy indemnify for a fixed daily amount or simply reimburse for actual costs? Most policies are indemnity plans which can cover incidental costs versus reimbursement contracts which cover actual costs. Reimbursement plans generally pay less, but cost less.
- What is the daily benefit for home care and assisted living? Typical policies cover these conditions at 50 percent of nursing home benefits. Unfortunately, the cost of either can meet or exceed nursing home expenses.
- Can benefits be used as a pool of money for both nursing and assisted living / home care? A pool of money may use the maximum benefits of the policy sooner but at least the cost of both assisted living and home care is covered for the meantime.
- Can the benefit amount be increased later? If so, will underwriting be required? This can be a valuable option for meeting unanticipated care down the road. However, added benefits are

usually associated with higher premiums, especially if the new insurance is written at the insured's attained age.

- Can the benefits be decreased if the cost of the policy becomes too much to pay? Coverage will drop, but at least some benefits will be paid.
- Can benefits be purchased jointly for a married couple? The discount is typically 10 to 15 percent.
- Is a survivorship benefit available? Some insurance policies that cover both spouses have a "survivorship" benefit. Under a survivorship benefit, when one spouse dies, the other owes no further payments, as long as the policy has been in force for at least ten years.
- Will benefits be paid if the caregiver is a friend or family member? What about caregiver training? Some policies allow this under home care benefits. The daily benefit for informal care is typically one-half the home care benefit.
- How much does home care coverage add to the premium? Home care benefits are typically one-half
- The nursing home benefit but could raise premiums by 30 percent or more. Policies where home care benefits equal nursing benefits will probably increase rates about 50 percent.
- Is the premium for benefits more than 5 percent of the client's income? Some industry analysts believe that the cost of long term care should not exceed this threshold.
- Are premiums guaranteed to stay level? It's doubtful. Clients should know that rates can increase by state residency or by class of policyholder. Some say that clients should prepare for an average 50 percent increase over time. Remember, extremely low premiums today, might guarantee rate increases later.
- Is there a limited pay or "paid-up" feature? Non-forfeiture or paid-up features are an option that clients should know about. They can be expensive now but useful later, e.g., a working couple with strong income today can retire with a paid-up policy.
- Is there a restoration of benefits clause? If a policyholder receives care in a nursing home and recovers, the policy benefits may be restored to the original level.
- Does the insurer count days or years? Most benefits are expressed in years but insurers actually count days. In some cases insurers will count three or four days as a week. This is a completely unacceptable condition.
- Do benefits paid through an HMO count as a full day? Although it is rare, some policies count a day of care provided through an HMO as less than a full day. This could be a bonus for the insured.
- Do home health care and adult day care benefits pay for a full day? This can be important to the relief and effectiveness of the primary caregiver.
- Do nursing home / home health care benefits increase automatically? Nursing home costs have been increasing between 8 and 9 percent since 1985. A cost of \$110 per day today will run up to \$513 in 20 years at 8 percent inflation.
- Is the increase based on the Consumer Price Index, Medical Price Index or is it fixed? No one knows the future, but if benefits at least kept pace with inflation the policyholder should have some form of additional protection against rising costs.
- Is there a "cap" on the amount benefits can increase? Beware of companies that "cap" their inflation increases to two or three times the base benefits.
- Are future benefit increases available on demand? Some policies offer the option to increase benefits every so often at the client's attained age. Look for additional underwriting and be alert to any condition that eliminates this option if it has been offered and refused by the policyholder a specific number of times.

- What kind of inflation protection is offered? Protection can increase at 5% compounded or 5% simple. The corresponding increase in premium would be about 60% and 50%. A daily benefit of \$110 today will grow to \$292 in 20 years at 5% compounded vs \$220 under 5% simple.
- What is the cost of waiting to buy inflation protection later? Policies that allow the purchase of additional coverage later can be cheap today but expensive down the road. A 65-year old might pay only \$770 today for a policy with optional increases compared to \$1,598 for one with automatic protection. In 20 years, however, the policy with optional increases could cost over \$5,000 compared to the same \$1,598 for automatic benefit increase protection.
- If inflation protection is too expensive for a client today, is it cheaper to just increase benefit levels? Perhaps. A premium for higher benefits but no automatic inflation protection will most likely cost less today. The risk taken is that clients may be unable to afford the coverage needed in 10, 20 or 30 years or simply have to accept lower benefit levels than would have been provided with automatic protection. These are trade-offs that need to be discussed with clients.
- Are bathing and dressing on the list of daily activities? If a bathing or dressing disability is a trigger of coverage, policyholders will have a much easier qualification and will qualify sooner since these are two of the first daily activities that chronically ill people are likely to lose.
- Are activities explained in different ways than other policies? Some define an eating disability as the inability to feed oneself while another may define it as the need for someone to watch over the party eating. Look for clarification on all activities of daily living as well as terms like: assisted living, walking or wheeling, cognitive impairment, ambulating, transferring, etc.
- Does the policy assess physical activities on a “standby” or “hands-on” basis? IRS 97-31 rules clarify the difference: “Hands on” assistance means the physical assistance of another person without which the individual would be unable to perform the ADL. “Standby assistance” means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL. Policies that cover only individuals requiring “hands-on” assistance would generally provide fewer benefits than one that included “standby assistance”.
- Will the policy pay on a “medical necessity”? Patients can be too frail to care for themselves from a medical condition like coronary disease, yet still able to perform daily activities. “Tax qualified” plans do not recognize medical necessity.
- Are there special underwriting definitions? One company uses the term “standard” to describe its worst class. For another, it means mid-grade.
- Is there “lifestyle” underwriting that will automatically cause an application denial? One company says that anyone who needs assistance with housekeeping, shopping and household finances is simply unacceptable.
- Does the policy require special equipment installation before benefits can begin? Some insurers may require the insured to install grab bars or a shower stall in place of a tub before they will pay benefits. These restrictions are not favorable to the policyholder.
- What are the measures of cognitive impairment? Look for methods that fairly measure cognitive impairment using terms like thinking, reasoning, remembering, memory, etc. HIPPA provisions measure cognitive ability based on whether the individual needs “substantial supervision” to protect himself from threats to health and safety.
- Is cognitive impairment measured separately from physical measures of ability? A company that uses physical methods to determine cognitive assessment may overlook people who can pass the test or perform daily activities but forget how or why they did them. Worse yet, their mental impairment could become a threat to how they do them in the future.

- Does the policy pay for home care alterations? Some will pay for stair lifts, ramps, grab bars, etc.; allowing an insured to receive care at home.
- Is there a return of premium or non-forfeiture option and how much does it cost? Clients are always concerned about paying insurance premiums and getting nothing in return. Offering them this option may increase premiums by 30 to 50 percent, but they will be certain to get something out of the policy.
- Is there a vesting schedule on any return of premium? Return of premium riders typically start or “vest” after five years. Some return more as the years go by. The return of premium is paid upon termination of the policy by lapse or death.
- Determine how the policy’s non-forfeiture options work. Non-forfeiture options will either return premiums or pay benefits. The benefit may be purchased as “full” (it accrues regardless of claims paid) or “limited” (claims are subtracted from any premiums or benefits paid).
- Non-forfeiture and return of premium options may be better suited to the policyholder who doubts he will use his coverage but still wants something out of the policy. He would have discretionary income and liquid assets to make the increased premiums. In essence, the cost of these additional options, represent a potential loss in the time value of money.
- Is there a cognitive reinstatement option? Where mental impairment has set in, policyholders may forget to make premiums payments and risk cancellation. This clause allows reinstatement for up to five months so long as all back payments and proof of cognitive impairment is made.
- What about other useful policy features? Some examples of options to discuss with clients include bed reservation (If an insured goes home, bed space is reserved in case he returns within a specified period) for nursing homes, waiver of premium, respite care and survivorship benefit.

Annuity Analysis

Sales conduct concerning annuity investing first involves fact finding to determine what portion, if any, annuities should play in a client’s overall financial plan. Next, a needs analysis should be conducted to uncover growth vs. income requirements, risk tolerance, liquidity specifications, now and in the future, and whether tax deferral benefits are worthwhile to pursue.

Who should invest in annuities? One rule of thumb follows that a client looking for a long-term investment with a tax bracket greater than 15 percent might consider annuities. Other likely candidates include moderate or high tax bracket individuals looking for a conservative way to shelter current income or growth over a long period of time. Fixed rate annuities might be an alternative for CDs, GNMA’s (Ginnie Maes), T-Bills or other similar obligations.

Variable annuities are better geared to individuals who seek tax deferral, yet are willing to ride with the ups and downs that accompany stock and mutual fund investments. Once an annuity can be established as an appropriate investment opportunity, agents must carefully weigh the following choices and discuss the same with each client:

Immediate Annuity vs. Deferred Annuity

Clients may have current income needs or the desire to defer income for greater growth. Perhaps a combination is appropriate. Tax planning and liquidity are key considerations for the agent.

Single Premium vs. Flexible Premium

Client's generally have a lump sum to invest or need to accumulate by paying into a savings plan. Short and long-term liquidity is an important consideration.

Fixed Rate vs. Variable Rate

Client's may have needs to lock-in their yields or go for growth. One group is typically a CD type investor as opposed to those who are willing and able to incur greater risk. Agents needs to carefully explain the potential loss of principal possible in variable plans. Agents should review potential interruptions in return of principal and yield that can develop with either fixed or variable contracts.

Yield vs. Guarantees

It is logical that the stronger the guarantee the lower the yield. Agents must explain that a higher first year yield may include bonuses or special incentives to invest that later disappear. This type of contract should be compared to other contracts that may offer a slightly lower yield that is locked in for a specific period (determining overall predictable yield over time is important due diligence).

In the same vein, a disclosure would be appropriate as to the method used by the insurer to adjust yield. A contract with a guaranteed yield spread may be more appropriate for some clients than a yield that is adjusted by the insurer's board of directors.

Equally important is whether yield is banded (yields are adjusted separately for certain blocks of investors or are investors who entered five years ago given the same yield as new investors).

Yield vs. Liquidity

Clients demanding easy access to their money should be prepared to settle for lower overall yields. Agents need to go farther to determine special needs such as the potential for large sums of money to pay for a potential illness or nursing home. Certain contracts allow penalty free withdrawals for special circumstances. Due care dictates that agents carefully and clearly explain all surrender charges associated with the contract and when they occur.

Maturity Options

Annuity contracts may mature at specific ages. This can affect both a client's long-term investment planning as well as tax planning. A client wishing to plan for long term deferral to age 95, for example, might be disappointed to learn that the contract must annuitize at age 85.

Further, agents must disclose the potential tax effect of a maturing annuity. Pre-1981 Annuities deliver principal first, then tax interest or appreciation. Post 1981 annuities tax interest or appreciation first then deliver principal.

Also to be considered is annuitization of the contract where a systematic withdrawal and payoff of the contract over time delivers some principal and taxes interest and appreciation with each payment.

Withdrawals & IRS Penalties

Where the client is withdrawing all or part of an annuity contract prior to age 59½, he should be apprised of the ten percent IRS penalty for early withdrawals. At present, this can only be avoided where the annuitant dies or becomes substantially disabled or, where annuitization is chosen within one year of investing in the annuity contract.

Guaranteed Death Benefits

Where agents assist in estate planning, due care would involve a disclosure concerning death benefits. Most fixed rate contracts guarantee the return of principal and any appreciation (interest left to grow). However, agents should uncover and review factors concerning potential surrender penalties or how they may be avoided, as well as the basis of the guarantee.

Is the death benefit guarantee, for example, the greater of all contributions of principal or simply the value of the contract on the date of the annuitant's death?

Settlement Options & Taxes

Clients should be made to understand that, at best, annuities represent tax deferral, not tax free income. Unless the beneficiary of the annuity is a surviving spouse, taxes on the accumulated growth will be due. There is no step-up in basis. The tax liability is the difference between the amount invested subtracted from the value of the annuity contract, multiplied by the beneficiary's tax bracket.

Options to mitigate this include five year or lifetime annuitization of the contract. Other settlement options that should be discussed with the client include possible options such as life annuity, joint and last survivor, lifetime with period certain, etc.

State Guaranty Fund Coverage

Rules governing state guaranty coverage should be disclosed to the client. If the State does not permit advanced disclosure concerning guaranty fund protection, the agent should privately exercise diligence in planning annuity purchases. The primary concern; is the full amount of the annuity covered against insurer failure? Perhaps due care is served by diversifying among several insurers and/or between fixed and variable contracts to take full advantage of guaranty protection.

Titling Options

If the agent is advertising tax and estate planning advice he should disclose the consequences of titling contracts. Where no tax or estate counseling is provided, the agent should still exercise due care by disclosing the fact that titling consequences may result and offer to refer a competent attorney or tax expert before any purchasing decisions.

As a general rule, the death of an owner or annuitant triggers a death benefit which carries tax liability. Unless the survivor beneficiary is the spouse, the beneficiary must take a lump sum and pay the tax or annuitize over a minimum five-year period.

An important area for agents to investigate is whether the annuity contract enforces or waives surrender charges where a death of the annuitant or owner has occurred. In some contracts, the surrender charge can be deferred where an owner dies and a contingent owner is allowed.

Essential Annuity due Care Questions

- Is the client interested in growth or income?
- Is the client interested in current income or retirement income? How soon does he need to start receiving income?
- How much risk is the client ready to accept today and in the future? Could he stand the loss of his entire investment? How would an interruption in income affect him?
- What are the client's liquidity needs in the short-, intermediate- and long-term?
- What is the client's federal/state tax bracket? Does tax deferral through annuities make sense?
- Is the client under age 60, and is it likely that he will need to withdraw major portions of the annuity in the future? Will the ten percent penalty offset the benefits of tax deferral?
- Does the client demand full and complete protection of principal? Or, can the client afford to take risk in hopes of greater appreciation using variable contracts?
- Is the preservation of principal more important to the client than the effects inflation may have against a fixed yield?
- What are the survivor spouse/family needs in the event the client dies? How could these needs be accomplished?

Business Insurance

The risk managing agent recognizes that due care extends to businesses as well as individuals, since businesses are composed of the same people. The illness, disability or death of these people represents an exposure to businesses in terms of their survivability and commitments to principals, employees and their families.

Sales conduct in business analysis involves a determination of the reduced revenues and increased expenses that may result from the death or disability of a key person in the business, including the possible costs to replace or sell the business, if necessary. The degree of risk protection in business insurance varies by the person who is affected and the legal structure of the company. Following are some due care considerations for three major forms of ownership – sole proprietors, partners and corporations:

Sole Proprietorships

There is no legal distinction between personal and business assets: debts of the business are debts of the sole proprietor's estate. Agents should determine needs or pre-loss arrangements of the surviving family to continue the business, sell it or liquidate it in the event of the owners death and disability. Capital deficiencies can be filled through the appropriate insurance line.

Partnerships

The legal relationship between partners is personal: each is fully responsible for acts of the business and business debts of all others. If a partner withdraws or dies, the partnership must be terminated or reorganized. The disability of one partner can also create a significant financial strain on the entire business.

Due care planning here involves learning the wishes of the surviving family and surviving partners. Where a deceased or disabled partner's family wishes to exit the business, a buy-sell agreement can satisfy the purchase of his share, with the business passing to the surviving partner. Alternatively, the heirs of the deceased may become partners or sell the lost partner's interest, assuming this is permitted in the partnership agreement. Again, pre-loss arrangements covering the possibility of reduced revenues and higher expenses during this transition must be considered.

Corporations

Most agents will deal with the "close corporation" where the stock is closely held by a few individuals and not offered for public sale. Typically, the stockholders are also employees of the company. In this case, situations similar to the partnership can develop.

A key employee or stockholder can become disabled or die creating additional financial burdens on the company. Most corporation charters provide that remaining stockholders can purchase the share of the withdrawing or deceased shareholder. The risk manager needs to uncover the "formula" for purchase and plan available funds via buy-sell policies, disability protection, health care, etc.

Other significant due care factors concerning business insurance include planning for taxes and liability. For planning purposes, most transfers or sales of business interest become part of your client's gross taxable estate for purposes of death taxes. Income taxes become a factor in corporations where the challenge is to transfer assets out of the corporation without claims of dividend.

Essential Business Insurance due Care Questions

- Who will control the business when your client dies or becomes ill for an extended period?
- Will there be a market for the business if it has to be sold?
- Will the business provide adequate income for the heirs of your client?
- How will the value of the business affect the taxes and liquidity needs of your client's estate?
- Will the client be able to continue in business if one of his associates dies?
- How will working capital be kept intact where a partner or owner dies or is seriously disabled?
- How can a business be transferred to a new owner without shrinkage in value?
- What will become of your client's interest in the business if he or she retires?

Property Casualty

Risk management in the property/casualty arena is extremely complicated, yet the primary goal is the same as other forms of insurance: the transfer of risk. However, a higher standard of due care and agent liability exist in property/casualty because of binders, indemnity disputes and redlining.

A binder can be written or oral. At the point when the client says "I want it" and the agent says "You're covered", a binder has occurred. Immediately upon creating any oral binder, the agent should make note of the terms of coverage, when the binder was made and the parties involved. Further, to reduce the possibility of disputes, the agreement should be reduced to writing as soon as possible. Abuses occur where agents do not have binding authority, yet lead clients to believe they do. Likewise, clients may use binders as a means of obtaining free insurance for limited periods.

Property and casualty insurance contracts are contracts of indemnity in that they provide for compensating the insured for the amount of loss or damage. Due care is accomplished when an adequate amount of compensation is provided that will avoid profit or loss from a peril or hazard.

Elementary insurance defines a peril as the cause of a loss. Fire, lightning and collision are all examples of perils. A hazard is anything that increases the chance of loss. A loose gas connection to a main heater system is an example of a hazard.

Hazards, however, can also take shape in "morale" form. Reckless driving is one such example of a morale hazard. While there are, as yet, no formal rules on insurance redlining, there is pending legislation that would force insurers to comply with rules similar to Community Reinvestment requirements now imposed on banks. If passed, a majority of the burden would fall on underwriters. However, agents should be aware that clients living in inferior, low income or minority communities should not be denied application for coverage. The logic behind this is obvious. Without access to insurance, clients would not be able to buy housing.

Compared to life and health contracts, it can be said, that fewer property/casualty policies are read by clients. There is generally less understanding of liability or casualty matters, and therefore, a greater reliance is placed on agent advice and counsel. That is why proper sales conduct would encourage clients to read their policies and help them review the fine print to fully understand exact limits of coverage, define perils, clarify what constitutes a hazard and recognize policy owner duties. Having specimen policies available for this purpose should be standard procedure.

Areas where agents should exercise additional due care involve the "agent as counselor". Insurance is the first line of defense in asset protection. The role of the property/casualty agent in preserving what clients have already accumulated is vital. This should not occur, however, without also recognizing the value of other forms of insurance.

A deluxe homeowner's policy should be scaled back where high premiums might not allow clients to purchase basic health insurance. There may also be validity to the argument that insurance premiums should not be so excessive as to preclude clients from starting necessary retirement savings plans.

In addition to these points, there are many contributions that can be made by agents to promote greater client understanding of risk, loss control and proper valuation. By educating clients in these disciplines, a higher level of insurance efficiency will be realized. The result can be stabilized or lower premiums through a lower claims experience. It is true, that this may not initially improve agent commissions, but in the long run client retention and income stability should be greater.

Essential Liability due Care Questions

- What is the insured's "insurable interest"?
- Is the peril covered?
- Is the property covered?
- Is the type of loss covered?
- Is the person covered?
- Is the location covered?
- Is the time period covered?
- When does the policy take effect?

- Are there hazards that exclude or suspend coverage?
- What are policy owners duties after a loss?
- What are the insurer's options in settling a loss?
- What are the time limits for the policy owner to recover from the insurer?
- What are the time limits for the insurer to pay a claim?

Next, a due care discussion might include:

Risk

A client's perception of risk influences how insurance dollars are spent and, to some extent, how the industry is regulated. Unfortunately, much of society has set a low priority on reducing risk relying on the motto: "That's why I buy insurance". Many in the industry, however, feel it is extremely important to reassess societal views on risk by assuming more responsibility for risk consequences. An example would be clients who continue to build in flood plains or high-risk fire areas, despite knowledge of their existence. When disaster strikes, should these individuals receive subsidies through taxpayer financed state and federal disaster aid, government flood control projects and mandatory shared-market insurance programs?

Should accident victims who violate seatbelt laws receive full compensation? Should people who live in hurricane and earthquake country be responsible to better secure a structure with inexpensive metal ties? Some believe that people must realize what they can do for themselves before risk priorities can change. Agents can play a valuable role in helping clients accept a certain level of risk and strategies to reduce it.

Loss Control

In the insurance industry, the process of risk reduction is called loss control. Loss control procedures involve the steps necessary in eliminating exposures to risk and reducing their frequency or severity. Today, loss control makes the workplace safer and reduces a broad range of liability exposures in homes as well. Offering loss control advice and services to clients has potential rewards as well as risks.

Reasons agents might consider advising clients on safety issues include client credibility, client retention, new client generation, insurer qualification and attractability, favorable insurer status and additional profits where "advice fees" are permitted by law.

With competition stiff, some larger agencies are establishing entire subsidiaries to perform loss control for-fee services. In these cases, loss control fees can represent from two percent to ten percent of total agency revenues. Smaller companies may contract to outside loss control consultants or simply rely on insurer provided services. Loss control services can run the gamut from standard, non-controversial safety recommendations to complicated compliance advice.

Whatever level of service provided to attract or retain clients, agents should realize that loss control advice exposes him to additional liability. There may also be statutory violations, particularly in the commercial area, for offering safety expertise without required licensing.

Code compliance is an extremely important area of loss control. It is a discipline usually reserved for underwriters and typically outside the venue of agents. This does not mean it should be ignored by

the agent. Due care should involve the agent at least to the extent of a physical inspection of the property to determine that fire sprinklers are indeed in place or that a security fence has been installed around a construction site before delivery of materials.

The importance in doing so is underscored by a mitigation of exposure when an accident hits: particularly by third parties.

Valuation

A recent survey by a well-known real estate statistics firm found that almost 70 percent of the homes in the U.S. are underinsured by an average of 35 percent. With an increased awareness of this problem, many insurers of large policies are sending appraisers to high value neighborhoods to determine if policy replacement values adequately reflect current values.

In addition, companies are directing it encouraging agents to re-evaluate coverage levels. In many cases, this involves inspections of properties to account for recent improvements, such as finished basements, patio covers, garage conversions; deterioration; code compliance to rebuild; i.e., new hurricane or earthquake standards; and illegal uses (a business run out of the home).

Bringing inadequately covered premises to full coverage levels increases underwriting income, which may allow a carrier to lower rates within a class of policy owners. Equally important is the liability protection afforded carriers and agents.

Homeowners Insurance

Agents should exercise due care in several important capacities:

Selection of Policy

The selection of policy type (HO-1, HO-2, HO-3, HO-4, HO-6 and HO-8) should be a function of client need. Obvious factors to consider include dwelling type, dwelling size, dwelling construction, dwelling replace ability, additional structures, type and extent of personal property, loss of use and basic liability.

Refinement of the process occurs where agent due diligence uncovers clients the true "limits of need" and special circumstances. This can only be accomplished by interview or systematized fact finding concerning key issues:

Value

The amount of dwelling insurance requested is typically a reflection of the mortgage amount. Does this reflect the true replacement value? Is an appraisal in order for larger policies or where a special construction has been used?

Remember, like kind and quality does not mean "exact" kind and quality. Clients must understand that replacement cost is limited to the style, quality and function of the destroyed or damaged property. Few or no allowances are made for increased costs of repair or reconstruction caused by ordinances or laws regulating construction or repair. An example is new construction school fees or

special fees that are currently charged for construction that were not around when the client's house was built.

Concerning personal property:

- Does an inventory exceed policy limits?
- Is replacement value available?
- Should items be "scheduled" like paintings, historical documents, original manuscripts, exotic pets?
- Are "sub-limits" of the policy meeting client needs, cash, gold, coins, stamps, securities, deeds, trailers, jewelry, watches, furs, precious stones, silverware, guns?
- After primary values are established, the client's "insurable interest" must be determined since a policy owner will not recover for an amount greater than their insurable interest.

Eligibility

Due care discussions with clients should cover circumstances where their eligibility to recover a claim may be jeopardized.

- Is the policy owner the intended owner occupant or does he intend to rent the property?
- Will only one family occupy?
- Is a business being operated out of a home?
- Are there code violations like additions without permits, zoning violations, etc.?
- Will the client be unable to perform his duties to mitigate losses (draining pipes to prevent freezing, maintaining heat if the structure is vacant, minimal repairs to protect the property from further damage, etc.)?
- Is a detailed inventory necessary to track descriptions, purchase dates, values, etc.?
- Are clients aware that they should hold on to damaged property and make it available for adjuster inspection?
- Do clients need to produce books of account or fill out a proof of loss?
- Will the client be available to assist and cooperate with the adjuster?
- Are insured's aware that they should not make any voluntary admissions of guilt or make voluntary payments to someone they have injured?
- Many of these circumstances can be brought to surface in an initial meeting or physical inspection of the property.

Deductibles

Clients should be apprised of their deductible options. Although higher deductibles mean lower premiums and lower agent commissions, they represent a fair opportunity for clients accept part of the financial consequences of risk taking. This, in turn, can lead to fewer claims and a generally more stable client.

Policy Exclusions

If the policy is in "readable form" it should be easier for the client to pinpoint policy exclusions. Some obvious disclosures, however, should include exclusions related to damages caused by earthquakes, flooding, sewer flooding, flooding driven by wind, power interruption, owner neglect, war, freezing of

appliances or pipes (especially if vacant over 30 days), theft of a dwelling under construction, breakage of glass if vacant over 30 days, continuous or repeated seepage from plumbing or heat & air system, normal wear & tear, latent defects, mechanical breakdowns, rust, mold, wet or dry rot, contamination, smog, settling, cracking, expansion of pavements, patios, foundations, walks, walls, floors, roofs or ceilings, rodent or pest infestations.

Liability & Liability Exclusions

Primary to determining liability limits is the client's overall exposure.

- What is his or her personal net worth that could be at risk?
- Will the limits of the policy or an umbrella cover the exposure?
- Are there any liability exclusions in the policy that leave the client uncovered?

Some common areas of neglect include: Boats over 50 horsepower, aircraft, motor vehicles loaned or rented by the insured, certain professional services, most business pursuits, outside premises, cases where insured is liable for worker's compensation, for damage to property used by or rented by the insured.

Auto Insurance

Auto policies are typically divided into different segments covering liability: medical, uninsured motorists and damages (comprehensive, collision, towing, labor and transportation expenses). Insuring agreements traditionally offered "split limits" which apply to each person for each occurrence of liability, damage.

Today, the trend is more toward a single limit of liability, which can be expanded within the policy or through the addition of umbrella coverage, that applies to all covered liability losses arising out of an accident regardless of the number of persons injured or the amount of separate property damage. Minimum due care considerations in this area include:

Policy Limits

A needs analysis to determine that liability limits of the policy adequately shield client assets and meet financial responsibility laws of the state which may assign specific minimums relating to liability, bodily injury, property damage and/or uninsured motorist coverage.

Policy Eligibility

Clients should be apprised of the specific vehicles eligible for coverage (private passenger autos owned or leased, longer than six months) and those which are not eligible (less than four wheel vehicles, autos used to carry persons or property for a fee) and those needing to be named as additional vehicles (trailers, off-road vehicles).

Clients should also be advised that new or replacement vehicles must be reported within 30 days of purchase to receive full coverage. Clients with poor driving records should be referred to assigned risk plans or "fair" plans organized through state programs.

Policy Conditions

Agents should direct clients to specific areas of the policy pertaining to "duties of the insured after an accident". Clients should be told that they should promptly notify the company of the accident, the time limits within which they should act and steps that they should take to reasonably protect the covered auto from further harm or damage.

Policy owners must provide sufficient evidence of loss, cooperate in any insurance investigation and notify the police if a hit-and-run driver is involved or if the covered auto is stolen.

Policy Endorsements

Clients should know the options they have to broaden their coverage to include coverage such as full replacement cost, towing and labor costs, rental reimbursements, specialized vehicle coverage, extended non-ownership liability, additional damage coverage for special vehicles, named non-owner endorsements, coverage for special personal property coverage for items like tapes, CDs, CBs, portable phones.

Some attorneys might advise agents to prepare a written list of available endorsements and the applicable cost to present with the original quote. Clients who incurred claims but refused the option to buy these endorsements would have a difficult time pursuing agents for not making them available.

Policy Exclusions

Due care discussions should also disclose, to clients, items of coverage specifically excluded. Examples include: property being transported, bodily injury to an employee of a covered person, motorcycles, off road vehicles, etc. Also excluded is coverage in areas outside the United States, its territories or possessions and Canada. Clients should understand that an endorsement for extended coverage should be considered when traveling outside these domains.

Policy Effective Date

It should be clear that coverage begins at 12:01 AM standard time on the date of inception to 12:01 AM on the date of expiration.

Named Insured

Who is the insured? Is the insured the policy owner, his spouse, a resident of the household, other family members?

Auto User

Is everyone who uses the auto a named insured?

Associated Named Entities

What is the name of any other person or organization who may not use the auto but may still have legal responsibility for the acts of omissions of the covered insured?

Commercial & Professional Lines

Commercial and professional insurance takes many forms: investment and commercial property coverage, business owners insurance, farm coverage, commercial auto plans, commercial liability policies, for directors, officers and professionals, workers compensation and more. A full discussion of each goes beyond the scope of this course. However, there are some important due care factors for agents to disclose and discuss with clients.

Policy Limits

As with most other forms of insurance, a client needs analysis should determine the extent of assets to protect, including any personal exposures. Policy endorsements and/or commercial umbrella protection may be considered as options. Special occurrences may have individual limits which must be evaluated for each client. For example, a "products completed" limit may be small for a bakery but should be expanded for a lawnmower repair service.

Eligibility

Rules of eligibility in the commercial arena are very complex. Clients should be aware of all limitations that might exclude coverage, including building size or height restrictions (buildings not exceeding 15,000 square feet and no more than four stories); business class restrictions (office uses permitted/manufacturing prohibited or retail permitted / restaurants prohibited).

Where liability is concerned, is the policy based on a "claims made" basis or a "claims occurred" basis? Clients should be well informed that coverage may exist only while they are in business and paying premiums. A claim made ten years after a client retires can be financially devastating.

Policy Endorsements

Due care should involve the listing of available options to extend coverage, reimburse for loss of use, loss of rents, loss of income, business expense coverage, builders risk protection, for buildings under construction, add or exclude specific accidents, products, work or locations, employment occurrences (termination, defamation, discipline, discrimination, etc.), liquor liability, products completed protection, pollution liability, malpractice, errors and omissions, personal and advertising violations, contractual liability, employee use of vehicles coverage, product defects or deficiencies, product recall protections, inflation upgrade protection, replacement cost coverage, personal effects protection, debris removal.

Scheduled Losses

The exact property or premises covered should be disclosed, buildings, insured's business personal property and the personal property of others located at the business premises.

In the case of liability policies, premises and operations exposure is the heart of coverage. Options should also be disclosed concerning upgrades to broader forms of coverage perils like extended reporting periods or extending coverage beyond termination of the policy, earthquake damage, crop insurance, livestock, loading/unloading accidents, window glass breakage, falling objects, weight of snow, water damage.

Policy Exclusions

As important as what is covered, clients should understand exactly what is excluded: Building ordinances, government actions, power failure, water damage, bursting pipes, explosion of steam boilers, mechanical breakdown, money, animals, autos for sale, legal property, underground pipes, fences, antennas, signs.

Named Insured

Since multiple parties may share insurable interest, it is important that all parties understand that the "first insured" is typically the "notified insurance partner". In the event of cancellation and policy changes, the conditions of the policy normally name the first insured to be responsible to notify other named insured's. In essence, the first insured is the "point man" for most policy transactions.

Beyond Insurance Needs

As solid as they seem, conventional methods of determining client suitability are today considered groundwork - a basic approach. A new level of sophistication is needed in response to a more complex world. Looking outside the box, suitability today must consider the following strategies and disciplines:

A Solutions Orientation

Clients, who have needs, also need solutions. A responsible agent understands that this starts with matching specific needs of a client to dozens of policy features and benefit options. When all is said and done, however, a responsible, solutions-based agent must take the final step to assure himself and client that an insurance or planning suggestion is the most effective way to handle economic and health needs.

You must obtain client answers to the following questions:

- Does this make sense to you?
- Have I given you all the information you need to make a decision?
- Is there something else I can answer to assure you that this is the right solution based on your needs?

These are essential questions because they help "clear the air" circulating around any doubts or concerns your client may have. In addition, they can help limit your liability if something goes wrong down the road. A positive response to these questions is the feedback you need to know that you have "gotten through" to your client and are providing some real solutions to some very important needs. The point is, do not define the needs of your client without input from them. Don't go it alone.

Client Needs Research

The important of "digging deeper" to uncover a client's true need cannot be overstated. You need to spend more time on applications and interviews. However, we live in a "break-neck" world where time is at a real premium.

Your client may not be willing to wade through a lengthy interview process. So, you must get to know something about who they are and what they want from your products and services before you ever meet them. It is called suitability research or client needs research. It involves sophisticated-sounding processes like market segmentation, psychographics, or generational marketing; but it is not difficult.

Why is this research helpful? Why should you determine insurance needs this way? Not all insurance consumers want the same level and type of service. Some clients require more "hand-holding" through frequent meetings, letters or constant phone contact. Others want to know they are being "taken care of" without the pampering.

When you conduct, client needs research, you will be able to assess your client markets and best identify their needs either way. This same process also helps you recognize emerging trends to expand your service to new client groups. It is not just about sales, it's about satisfying customer needs and serving them right for long-term results. You benefit from a consistent income and clients are more likely to receive better insurance coverage from someone they know and trust. What can you hope to learn by doing client needs research? Here is just a partial list:

- Strategic planning - in what direction are consumer trends driving your business? Where should you invest?
- New product/service development - what lifestyle need can your new product or service fulfill? What new products are opportunities?
- Product/service redesign - what changes in consumer lifestyles affects your product or service? How should you change your offerings?
- Positioning - what lifestyle do you need to satisfy that competitors do not? How do you communicate your superiority?
- Targeting - what lifestyle characteristics define the consumer groups you want to/should target? What new groups are the best opportunity and most need your product?
- Marketing communications - what marketing messages resonate strongest with your target consumers? How can you minimize disconnects?
- Channels - what is the best way to communicate with your consumers? What channels should you choose?
- Pricing - what are consumers' attitudes about price, value, quality? How do they feel about spending and saving their money?
- Brand loyalty - how do consumers perceive the role of brand in the shopping process? How can you encourage strong brand loyalty? What programs work?
- Market share - what do consumer trends suggest about the future of your business? How can this help you create a sustainable competitive advantage over your competitors? What actions can gain you more share?

A New World Means New Consumers

Before we explore this new world of research you should understand that insurance consumers today are much more complex than the relatively homogeneous buyer of the immediate post World War II era. Values back then were stable and centered around a shared vision of the American Dream. Now, we see vastly different values, motivations, life experiences and insurance needs. By examining the various market groups that make up these modern-day clients and prospects, you will gain the confidence to understand their core needs and their motivation to insure in specific areas. The result

should net a better client-agent relationship, better coverage and better client retention down the road.

Client Groups / Cohorts

Client needs research focuses on groups or clusters of clients. Members of a group or generation are usually linked by shared life experiences such as pop culture, music, world events, natural disasters, heroes, villains, politics, and technology. These experiences create bonds that tie these groups together into what some researchers call cohorts. Because of their shared experiences, cohorts develop and retain similar values and life skills. And, research has proven that these same skills and values are more powerful indicators of insurance needs.

In their book *Rocking the Ages*, 1998, J. Smith and Ann Clurman suggest that every cohort group passes through the same stages in life: getting a driver's license, buying a home, the joy and pain of parenting and the uncertainties of retirement. Similarly, each generation or group we belong to must all deal with the same circumstances: economic downturns, wars, World Series. But, each group responds to these life changes and circumstances in different ways depending on generational differences. Therefore, it is likely that the insurance needs of one group are different from another.

To demonstrate this, let us look at the insurance history of today's seniors. In their younger years, virtually everyone bought whole life insurance to cover burial costs and/or to build a small pot of money down the road. You started with a small whole life policy and paid on it forever. Contrast this with boomers of today who more typically buy one or more term/universal/variable policies for \$1 million and up to cover huge mortgages, expensive college educations for their kids and / or staggering cost of living expectations if the breadwinner dies young.

Both generations bought homes and raised families, but the influences of their individual eras created a need for much different insurance products. The same is true for property/casualty and health coverage's. Generations today buy substantially higher liability and lifetime medical limits in response to more lawsuits and escalating hospital bills. Generations past were more likely to self-insure all or a portion of these coverage's because the legal consequences were not as grave.

Group Needs

Consumer research experts say that you would be making a mistake to assume that just because your customers behave in the same ways they will have the same insurance needs. For instance, an insurance agent who has successfully met the needs of a 50-year-old baby boomer with a specific product line might be fooled to believe that the generations behind them (yuppies, Xers, etc.) will find the same products satisfactory.

Boomers, for example, remain more free-spirited from habits formed early in life. They are not the savers their parents were. Now is more important to them, even though they are getting closer to retirement. Xers, on the other hand, are a more savvy generation willing to take on the challenges they face. For Xers, hard work is a pragmatic necessity and they tend to be more careful in planning for the future. In a few ways, they are embracing some of the values of seniors who have seen more uncertain times. As an agent, you need to understand these trends and reposition yourself to better serve them. We can learn more about this using other industries.

In the late seventies, for example, publishers of a magazine called Apartment Life needed to change their image to respond to a wave of prosperous, independent Boomers. The country was emerging from a recession and urban-oriented Boomers no longer wanted to live in cheap "singles apartments", but they weren't quite ready to move to the suburbs like their predecessors (the Seniors).

To respond to this shift, the magazine successfully changed its name to Metropolitan Home and emphasized luxury and prestige apartment living. In a like manner, agents today need to find a common ground with every client group he serves. It would be a mistake to judge people by their appearance and selling on price alone may no longer be the path to keeping customers happy.

Know Your Clients

We have only lightly discussed a few of the significant client groups you will encounter in your business as an insurance agent: Seniors, Boomers, Generation Xers and Nexters. Each of these generations have unique work ethics, styles and views on issues like quality of product, service and their need for insurance. The agent of the new millennium strives to know as much as he can about these consumer groups because providing and servicing their insurance needs is no longer the homogeneous effort it was years ago.

Your ability to respond to their needs will determine your success in developing long-term business relationships where all parties involved are rewarded. In addition to knowing these clients, you must develop ways to work with them. If you are a young agent, for example, will you be able to convince a senior that you are capable of understanding his needs and meeting them. Older agents may have similar problems getting younger clients to listen or see value in their experience. Let's look at the profile of these clients and the interaction issues you face in serving them:

Seniors:

(Born between the turn of the Century and World War II) They number approximately 52 million. Seniors accomplished their goals through hard work. They are a very "team-oriented" generation having weathered a depression and major world wars.

Almost half of the men of this group served in the military, which is probably why this generation is so well taken care of by the government. It also did not hurt that they saw seven of their own in succession in the White House, beginning with John Kennedy and extending through Lyndon Johnson, Richard Nixon, Gerald Ford, Jimmy Carter, Ronald Regan and George Bush.

Research has shown that different generations tend to catalyze or define themselves in the shadow of a momentous event or members of their generation. Defining moments for seniors include the bombing of Pearl Harbor, "a date that will live in infamy" said President Roosevelt. Heroes of this generation include MacArthur, Patton, Eisenhower, Winston Churchill, Audie Murphy, Babe Ruth, etc.

As seniors came of age after World War II, they were armed and motivated by the ideology to rebuild society. They shouldered the burden of ensuring foundations of a better life which, indeed, is the reason that the generations behind them experienced stability and growth. Their self-sacrificing was very aptly summed up by John Kennedy in his inaugural speech when he said "ask not what your country can do for you, but what you can do for your country". Things weren't easy, but that was ok. Seniors understood that hard work was its own reward and sacrifice a virtue.

Duty before pleasure was their creed and their commitment to accomplish their goal was lifelong, not just a temporary success. In essence, unlike many other generations, seniors had a clear sense of purpose to what they were doing: sacrificing for their children. Their individual struggles were shared by the entire nation, which led to an unprecedented era of cooperation and mutual support. Moreover, their efforts paid off.

Success seemed to follow anyone who worked hard. This only reinforced their core belief that anything worth having was worth working to get. Because they concentrated on their work and sacrifice, seniors have always looked to the outside for direction and guidance. Authority figures like Dr. Spock were highly praised, as was a general respect for government officials. Government programs flourished under the seniors starting with the GI Bill of Rights, which allowed virtually anyone to buy a house or go to school. The suburbs were filled with starter homes while the government provided the entire infrastructure.

The prosperity of the seniors, the respect they felt for institutions and their desire to conform all resulted into a true loyalty toward brand-name products. Seniors postponed many material rewards, but when they finally let loose, they bought up a storm: mostly brand names they saw on TV or in ads. Anything that portrayed a glimpse of the American Dream was an immediate success. Financial services were not complicated and interest rates were low for most of the senior generation. Seniors paid off homes, created large retirement savings accounts, secure jobs and retired earlier than the generation before them.

They are also richer, have more health benefits, better pension plans and live lives that are more comfortable. In addition, even in retirement they still want to conform as they flock to senior-oriented communities with names like Sun City and Leisure World. Smart marketers have also learned that you do not treat today's seniors as decrepit or broken down. They see themselves as active, health, happy and vivacious. Even those who are not so healthy or energetic dislike advertising or products that remind them of their age or problems.

Seniors like consistency and uniformity in their business dealings, as well as brand name companies. They like to conform and believe in logical matters. Conversations should stay "on the topic" and not get "too personal". Seniors are disciplined but they get frustrated like everybody else with things like poor service or poor directions.

The history of your products and companies are very important to this group because largely they base their decisions on what has happened in the past: What worked? What didn't? Details are also important because seniors are very uncomfortable with conflicts that arise after the sale. Seniors believe very much in law and order so products that might "push the legal limits" may be viewed with suspicion. Technology devices like voice mail, computers or e-mail are not their favorite things. In essence, you are dealing with a very conservative group.

Boomers:

(Born between 1946 and 1964) There are over 80 million Boomers alive today making them one of the largest consumer groups ever. Boomers are bound together by their early expectations, skills and values shaped unbridled economic growth. For them, the bubble would never burst. They grew up in some of the most optimistic, positive times.

With few economic worries to distract them, they felt free to focus instead on themselves, on experimentation and on fulfillment. It did not help that Boomers grew up spoiled and pampered by permissive parents and authority figures who considered self-expression good for them. Boomers grew up thinking they were special and the media gave them the spotlight at every turn. They were and still are the "stars of the show". They believe themselves to be more interesting than seniors or the Xers that follow. They also feel a sense of entitlement and expectation simply because of whom they are. After all, they are the best-educated and most sophisticated Americans in history. Personal freedom was a right not something to earn. They wanted no penalties for breaking the rules and complete impunity from criticism on the job.

For early Boomers, life was simple and orderly. However, this all changed with the Vietnam War, Watergate and the economic hard times of the later 1970's. For Boomers, all of these events represented "cracks" in their world. The system was in doubt and the Boomers saw themselves losing ground for the first time.

The post 1979 period was definitely a turning point in Boomer attitudes and expectations. A new desire for affluence emerged: "he who dies with the most toys wins" attitude. By the mid-1980's, economic and tax policies made this more pronounced by putting more money into the hands of Boomers who realized that they had to take care of themselves. It was an era of conspicuous consumption never seen before.

BMW's replaced VWs, designer jeans replaced tattered jeans and the Home Shopping Network came into our homes to make it all possible. Brands for the Boomers no longer dominated the marketplace. They wanted control. Discount and outlet stores thrived. This continued unabated until the shock of the '87 stock market. Suddenly, Boomers rejected the marketplace. Instead of "shop till you drop" the watchwords were "drop shopping".

By the end of the eighties, Boomers were actually losing for the first time. Even their kids were suffering because both parents were working. Debt was higher than ever and so was their weight. Boomers reasoned that they worked hard and played by the rules but still failed. Of course, they also believed that it was not their fault. They cast themselves as the victims – a resentment that lasted well into the 1990's.

Today, to a great extent, Boomers have regained their senses. They are realizing that they have created much of their own stress and they will pick their future battles more carefully. They are also realizing that they are in their peak earning years and they need to start saving for retirement.

It is important, say the experts, to remember that Boomers are rule breakers. Their individuality is more important than conformity. They have always done things different from the seniors before them. If it takes some spending to accomplish this, so be it. Boomers are quite service oriented. They want to be liked, yet they are driven and willing to "go the extra mile" with a tremendous sense to "prove" themselves. Boomers have been described as "the most stressed generation in history", however, they are reaching an age when they want to simplify their lives as much as possible.

Generation Xers:

Americans born after 1964 are already a powerful force in the marketplace, yet they are a Generation that is much harder to label. In numbers, they are smaller than the boomers and seniors with approximately 44 million among their ranks.

There are many common themes that apply to all of them, but the way they express themselves and the way they are influenced is much more diverse than prior cohort groups. Perhaps, to some extent, this is because this group is the most demographically diverse segment of the population. There are fewer Caucasians, and in some states, it is predicted that certain ethnic groups within the Xers will represent the standard, not the minority.

What are the issues that bind the Xers? In his book *Generation X*, Douglas Coupland describes them as "fanatically independent individuals, pathologically ambivalent about the future, and brimming with unsatisfied longings for permanence, for love and their own home." This is not a flattering description of today's youth and some believe it is simply the same old system at work: Each generation complaining about the other.

Statistics show, however, that GenXers have faced economic and social obstacles that did not exist for Boomers. Some believe, they have even more to overcome than Seniors. Older Xers witnessed splitting families, gas lines, stagflation, IRAN hostages, nuclear meltdowns and corporate meltdowns. Younger Xers saw more families that are splitting, homelessness, holes in the ozone layer and a lot of violence on TV. All of this instilled a certain air of survival.

While the Boomers inherited a world built-up by seniors, Xers feel they are left with the aftermath and conflicts of the Boomers. For some, the feeling is that everything needs to be fixed, especially if a Boomer has something to do with it. For the meantime, these issues have left the Xers with a detached attitude.

Jobs are dead-end, life is one big conflict. But many feel this too will pass because Xers are tougher than Boomers. They are much more determined to be involved and in control. They will tire of being victims and unlike the generation before them, they will not focus on a "live for today" philosophy.

How will Xers shape their future? Instead of muscle and sweat, they will be more resourceful. Sure, they can work hard when required, but they will more likely work smarter too. While seniors and Boomers would "forge ahead", Xers will sidestep and wait for an opportunity to develop. They are far more entrepreneurial and less trusting than Boomers. Self-help is their best protection against failure. In the spirit of the best survivalist, they are protecting themselves against tomorrow.

One of the most important tools for Xers controlling their space is the computer. While every generation is known to be experts of the technologies commonplace at the time, the computer skills and cyberspace prowess of Generation X is well known. It defines their vocabulary and communications. So much so, that the PC and other techno tools are simply part of the background. Some feel, however, that the impact of all this technology will also contribute to their uncertainty. It has created the risk of distancing themselves from "real life" and forced them to have everything presented in short spurts of information, much like web pages. This is truly a visual generation. They are less likely to read, but more likely to network quickly.

What is in store for Generation X? As Xers approach their thirties, they are taking their cautions and concerns with them, especially when it comes to families. Experts predict that they will not want to repeat the mistakes Boomers made in splitting households, nor do they want to inflict this on future generations. Stability in their household is a goal and success a dream with many barriers yet to overcome. Xers like informality and their approach to authority is casual. They are unimpressed with

authority. Instead of billing yourself as an insurance expert, for example, you might get farther with an Xer if you come to be known as their insurance "guru".

This group is also very skeptical. They have learned not to place their faith in others. Loyalty and commitment are secondary to getting "burned". With Xers, you need to tell them what it is. Tell them what it does. And don't make a big deal out of it. Of course, Generation X is technologically savvy. They take comfort in their knowledge of computers, e-mails and the Internet.

Nexters:

While this generation is now too young to be major insurance consumers, they represent a large base of the population (about 80 million strong) and they possess some unique characteristics that will make them noteworthy as future clients. This new wave is both optimistic about the future and realistic about the present. They combine the can-do attitude of seniors with the technical shrewdness of Xers. Some call them the "ideal citizens". They are resilient because they take things that might annoy other groups for granted. Goal setting and the 40-hour workweek, for example, are expected to achieve dreams. They will be the best-educated generation and their core beliefs are about government and the "establishment" is, in general, very much like seniors: conservative.

Serving Generational Needs

To be effective as an agent you need to know your clients and know how to meet their needs. You need to "empathize" with their current and past situation. Think of it as "walking a mile in their shoes"; imagine how they perceive you as their agent. Are you too young to gain the confidence of a senior? Are you too old to relate to a Gen Xer? Too stuffy? Are you going to fast? Too slow? Do you "speak" their language using words and mannerisms familiar to them? Is your demeanor so casual that a senior might think of you as rude or disrespectful?

This is not about "selling" something you have, it's about how to better communicate transactions so different clients can understand them better. For example, if you were approaching a Senior with a long term care policy proposal the insurance brand name would be important. But, in addition, be aware that Seniors have come to be somewhat distrustful of big business. You would need to do more to satisfy their need to know more about your insurer.

To be effective, you will also have to reach different client groups on different levels. Seniors and Boomers may not respond as well to websites as will Xers. Boomers will want more detail, while Xers want it short and sweet. Seniors will want to know all the risks in plain English.

While all groups want the best price they can get, just selling price is not enough. Every generation has demonstrated they will be willing to pay a little more with a guarantee of better service. As to efficiency, Boomers and seniors are pre-occupied about what goes on during the sales process. They see the sales experience as unpleasant. Xers, on the other hand are more worried about what happens after the sale since they feel that if a problem occurs, nothing will be done anyway.

Serving Seniors

Serving seniors effectively means you must respect their experience. They might like hearing from you how valuable it is to hear how things worked in the past and that their perseverance is valued. They might also like to see that you are part of a team to meet their needs. Messages, literature and

brochures should speak to issues of family, home, patriotism and traditional values. Use clear enunciation, good grammar and large type. Include "please" and "thank you" and avoid any kind of slang or near-profanity. Also, do not expect seniors to jump-in on a product you just presented.

They prefer to get to know you, what to expect from your policy and who is who with your companies. They will relate to the true story of your company from where it is to where it is going. Stress the long haul using "months and years" rather than days and weeks. Seniors will respond to the personal touch such as a handwritten note instead of an e-mail or fax. Also, strive to be a respected "mentor" or "coach" to your senior clients. Don't avoid the difficult issues and try to get agreement on potential problems.

Never try to take them by surprise; they need time to prepare for their decisions. Agree on a course of action and set a follow-up date. Financial discipline is still the foundation of this generation. Few of them will betray a lifetime of saving to be big spenders. They might be more willing, however, to spend money on look at something that might benefit their children or grandchildren because they are still the generation that feel they need to make something better for someone else. When it comes to something new or experimental, you will have a much harder time convincing Seniors. They are less likely to want something new before someone else has tried it.

One of the best mediums to reach seniors are lectures or seminars given by an expert. However, this group does not like to be in learning situations (small or large) in which they might look foolish in front of someone because they do not know the right answer. If you ask a question, make sure they can answer it. Information should be organized, well researched and supported by facts, figures, details and examples. Seniors like their information in condensed form. Also, few, if any, Seniors would like to be known as old. If you are appealing to them to contacting older clients, there is no need to point out that you are doing something a certain way because they are old.

Serving Boomers:

Serving boomers will be a challenge. Like seniors, they need to know that their experience is valued. Messages like, "you're important to our success", "we need your business" or "you will really make a difference" are important reinforcements. They need to know they are part of something dynamic and that in the final analysis "they" will be the winners.

Instead of historical significance, stress how your company and products are leading edge. Always focus on the future or near future, rather than the past. It is not specifically huge amounts of data that impress them, but the nature of the data being inside edge or "little known" to anyone else. Third party testimonials or articles from experts lend more credence to this group. If you need to coach or mentor a boomer, be tactful. Be warm and find opportunities for agreement and harmony. Ask lots of questions to get to their issues. Think of yourself as an equal but always ask permission.

Boomers want to win at most things, however, they are realizing that convenience can also be a good thing. You clearly need to be more detail oriented with Boomers. Technology is important but they are still suspicious. Boomers look for efficient organization of information. Pack it in, but make it easily available. Let them browse.

Brand names are not a "hot button" as long as they have choices. Value, on the other hand, is critical to their thought process. Because boomers see education as a means of climbing the ladder, they respond well to several learning mediums, especially when presented in a somewhat casual

environment. To boomers, lots of information is considered a reward not a liability. Start with an overview and give them an option to get greater into the detail later.

Seminars and workshops work good although they, like seniors shy away from involved role-playing. They like books, videos, self-help guides and audio tapes. Money will likely still be a problem for Boomers. After years of spending and lack of retirement planning, they need help. And, they will increasingly delegate these matters to experts. Solid instruments deigned to help them save are needed most. Boomers will continue to reject traditional methods.

Serving Gen Xers:

Serving Xers will be a different experience. Doing something their way with the help for the newest technology is how you get through. The fewer rules the better. The more feedback the better. Your product or service must be helpful in them "making their life easier" or "getting more our of life". Experience and traditional statistics are meaningless to this group: They will decide based on merit alone.

Make it easy for them to get information in snippets, rather than through a whole lot of reading and a good amount of "frequently asked questions" to ponder. Give them a lot of elbowroom to make a decision, but be there (feedback) when they need to ask a question. People in the Gen X category will be diligent but uncertain that anything will last. They are the most likely group to hedge or insure against bad consequences. However, asking them to plan for a faraway retirement is not high on their menu.

Xers are skeptical and do not like to be categorized. They do not want to be "preached" to about the benefits of a product. Tell them what it is, what it does and get out! Xers have little use for experts. They rely only on friends and self-help: Both are more trustworthy and less suspect than an "expert" is. The hard sell is not going to work because they have seen it all or they can access it for themselves right now. Lack of data does not bother them as much as lack of honesty. Get to the point and stick to the subject in an earnest way. Also, brand names mean less to this group than others.

Mediums to reach Xers vary widely. Statistically, however, they do not read as much as other groups. However, interactive CDs and internet solutions can be very effective. Gen Xers will judge you more so on your technical competence than on your people skills and you will not automatically earn their respect because you have a degree or professional designation. New and improved means little a Gen Xer. His idea of new is something on the extreme edge of what is there already. However, you can score points if you stress that you do things very differently than other agents.

Anticipating Needs

Little in life remains the same. Your clients and their surroundings are changing and so will their insurance needs. You must plan, even when things seem very confused. The fact is, the future is a blur for everybody. No one expects you to predict what will happen to your clients. As a responsible agent, you should at least have a pretty good "sketch" of what is going to occur just around the corner and a "faint outline" of what is further down the road.

Anticipating client needs is especially important today, considering the speed at which the world is changing. To grow and progress in your career, however, you need to equip yourself with the skills and knowledge needed to be proactive to the threats and opportunities of the future. Your very

survival and well-being could depend on your ability to anticipate and cope with future events and problems. What does the future have to do with understanding client needs? Simple: The future brings change and the need of your clients change as well.

To satisfy these new needs, agents must adapt. But when will the changes occur? What are some of the ways you will need to adapt? Interpreting future changes (at least from a "best guess" standpoint) should help you prepare better and get a jump on the many new responsibilities that change will bring to the insurance industry and your business. For example, it is a widely accepted premise that a large economic gap is developing between the wealthy and the poor.

The middle class in America are losing their purchasing power on the heels of income losses, unemployment, and antiquated skills. Knowing this, you might need to adjust methods of selling and servicing clients. Most will be less well-off than you are used to (looking for ways to stretch their insurance buying dollar with more term insurance or discounted casualty coverage) while others will be far better-off than the average guy on the street (looking for quality insurance products and ways to insure a high-end lifestyle). Can you adequately serve both? Can you re-orient your products to better meet their needs?

It will also be important to be on the lookout for events expected to occur in the future that will run contrary to historical patterns. You will need to monitor things to determine if an emerging trend is actually developing. Healthier eating habits, for instance, are likely to improve as consumers age. The toll they will take, however, may cause a whole band of widely overweight, unhealthy clients needing special medical and life insurance alternatives. There will also be wild-card changes that are completely unpredictable.

The presence and attraction of the Internet, for example, has taken the entire world by storm. The methods and practices you need to serve clients in the future may depend on your knowledge and practical application of Internet-based programs and communications. Your clients may insist on it or shun it. Either way, a plan to handle it is needed. Following are some of the significant trends and predictions that agents need to analyze and monitor:

Demographic Trends and Possibilities

- People are living longer and older citizens will represent more of the mix. In most areas of the world, people over age 60, who equal about 18 percent of the total population, are expected to climb to over 30 percent by 2030. The influence of older citizens will grow not only because of sheer numbers, but also because older citizens are becoming more affluent. Many young adults will never be able to afford the lifestyle of their parents.
- Senior groups like AARP and others are growing in influence with huge numbers of boomers coming to the fold. These groups will influence Medicare, Social Security and other policies facing seniors. Agents need more senior products and ways to help them meet or supplement their coverage needs.
- The changing profile of women: More disposable income, more education, more jobs, more sophisticated needs. The agent's perspective of the "typical American family" must change. Two-wage earners and a growing element of "Mr. Moms" will require a reversal in traditional insurance needs analysis. Women will need more life and disability insurance in order to cover the economic hardship of their loss to the family.
- Some women will have problem saving for retirement because their child-bearing responsibilities mean they work fewer years. Many are single parents with even less

opportunity to work. They will need help from very skilled financial advisors to make their money work harder.

- Minorities will soon become the majority in some areas on the heels of rampant immigration. Cities and regions will be more and more segregated by race, ethnicity and class. Schools and neighborhoods will be highly stratified: the wealthy and the minority underclass. A majority of whites, however, will tend to be less affluent and then before. Niche insurance needs will be amplified as various ethnic groups desire to be represented by someone who understands their core beliefs. Ethnic shopping centers and financial services centers will be developed. Services, products and information promoted in several different languages will be the norm (multilingual customer response centers, multilingual insurance agents).
- While traditions are a powerful force, a certain amount of attrition will occur where cultural consumers will fragment and diversify in their tastes and preferences and begin to explore other new and unique offerings or slowly adapt to American lifestyles.
- A large income gap is developing. Middle class Americans, even though better educated than the generation before them, will have fewer employment opportunities, less affluence and less wealth. Agents need to focus on the needs of a poorer middle class.
- The profile of entrepreneurs is changing. About 20 percent of all small business owners are under age 35 and women are forming businesses at twice the rate of men. The unfortunate side of this trend is that worker benefits are costs that few entrepreneurs can afford since they are already under the gun to keep up with payroll taxes, self-employment tax and other forms of government fees.

Technology Trends and Possibilities

- PCs and the Internet will empower consumers. Armed with automated systems, they will be able to make buying decisions without leaving home. Everyone will need a website. A movement toward buying insurance online will happen for a certain segment of the population. However, wise consumers will always involve agents in the mix for advice and as a buffer between insurance companies.
- As consumers become more accustomed to quickly gaining access to information, they will start to incorporate their technology skills into everyday life. Product recommendations as well as complaints will spread at an accelerated pace. Consumers will be looking for more information to make knowledgeable decisions and ways to be more efficient and productive. This thirst to devour more and more knowledge will eventually lead to excess information and the need for someone to unravel all the input. Providing product comparisons, options, features and prices will be an important service.
- The rush to the Internet will make it difficult for services and manufacturers to differentiate themselves from the crowd. Also, the more impersonal the world becomes with technology advances, the more people will need to be reconnected to other people.
- Relationship building will still prevail as the best method to serve clients.

Economic Trends and Possibilities

- The role of the private sector will become more important to consumers' financial wellbeing than the role of government. People will become more self-reliant as governments limit social spending. Self-health care will flourish as well the desire to control purchasing habits. Value in products and services will be high on consumer lists.

- Increased competition will keep a tight rein on prices. Product and service differentiation will become a critical factor to success. If your product does not stand out from the crowd, it may have to compete on price alone.
- The United States is gradually learning to survive without traditional smokestack industries. We are world's salespeople, shippers and financiers. While a manufacturing component will continue to exist for decades, it will become more technologically oriented; run by scientists and engineers rather than shop foremen. Manufacturing will be knowledge intensive rather than labor intensive.
- Networking, particularly among small firms, will increase along with greater customer supplier cooperation. Size will no longer be synonymous with success. Customers who only purchased from the large companies will shop around.
- Businesses and government agencies are buying more goods and services from outside sources rather than internally. Outsourcing will improve service quality as entrepreneurs obsess about winning and serving the customer. Home offices or small remote offices will allow employees to set up shop away from the main office.
- Continued downsizing will increase the pool of middle-class unemployed available to work as temporary employees. The trend toward smaller enterprises will also increase specialization of products and services.

Work Trends and Possibilities

- The number of full-time employed are falling as many white collar workers accept early departure packages and carve out new identities in skilled arena. Many of these people are boomers "getting out of the rat race" in a post affluent society mode. Some believe this is the start of the "American dream is over" movement leading to a society of "haves" and "have not's". As the simplicity movement grows, look for ways to serve basic needs.
- Because of emerging technology trends in the workplace, skills or professional knowledge will need to be upgraded constantly. Interpersonal and sales skills, in particular, must be sharpened as e-mails and teleconferencing accelerates and face-to-face meetings decline.

Life Event Trends and Possibilities

- A larger segment of aging adults means aging bodies, poorer vision, more cancer, more heart disease, osteoporosis, Alzheimer's and arthritis. People will become more focused on health and ways to protect it because the older we are, the greater chance we will have some personal experience with injury or disease.
- More aging consumers will demand services such as home maintenance, health care, home care and death care. Unfortunately, we will also see an overall increase of disease on the heels of drug-resistant strains of bacteria aid the continued spread of other infectious illnesses such as AIDs, tuberculosis, and malaria worldwide.
- Consumers will look for natural or alternative remedies and/or doctors more and more. They will be less willing to take on the risks of surgery and drugs if there are alternatives. Gone are the days when people will simply accept the doctor's advice without question.
- Longer life expectancy will make having children later in life a more attractive option for couples who delayed having children because of their careers. Many women who delayed childbirth may seek fertility therapy, hormone treatments, etc., which may lead to more miscarriages, pregnancy complications and multiple births.

- As consumers become more educated, have better access to information and buying options and are feeling more empowered, they will not hesitate to let their feelings be known. Intolerance for company mistakes, complaint handling, and price gouging and business practices generally will increase as consumers fight for what they believe. Increasing competition and technological advances will raise consumers' expectations even more. This will mean more for less, faster buying time, less complication, less effort before and after purchase, less risk, and fewer mistakes and handling of mistakes to their satisfaction.
- Grieving is on the rise. That's right, as the boomers head toward the final third of their lives, there will be more focus on grieving due to lost and ailing family and friends. Death and estate planning will be much in demand as well long-term care and Medicare supplements.
- Resurgence in smoking is anticipated as Gen Xers find new and exotic reasons to smoke.
- Smoking is now a social grace among many and some feel that a cancer cure will be found so "Why not enjoy". Consider new improved sales among flavored smokes, cigars and specialty cigarettes. Insurance costs will increase as tobacco users proliferate.
- Hospitals are becoming dangerous places to be as infected equipment and new bacteria strands kill more patients. It is estimated that more than 2 million people enter hospitals each year only to get sick with something other than their original problem. Health care costs will continue to be affected as will the need for home care and special procedures to assure sterile medical care.
- As governments and the medical profession grapple with escalating health care costs, one strategy will be a shift from hospital care to home care. People will be leaving hospitals "sicker and quicker". As the population ages more and heads home sooner, adult children will be taking on the role of caring for their parents more and more.
- The "casual" trend will continue as people value the quality of their life over traditional business methods. While this may translate into more comfortable clothes and the need for less formal offices, your clients will still want to know you are a professional. Your dress and surroundings are part of this equation.

Legal Trends and Possibilities

- Insurance companies and their agents will see increased activity in the area of civil rights claims, particularly those dealing with the American Disabilities Act (ADA).
- More cases will surface that challenge the AIDs/HIV policy exclusions and limitations. In one case, the limitation was outlined in the policy and listed in the data page entitled "Schedule of Benefits". The courts held that although the line pertaining to the limitation was clearly eligible, it was not highlighted, set apart, or emphasized in any way. Therefore, the limitation was not enforceable.
- Look for more of these "narrow definition" conflicts which may involve agents. An insurer denied a disability claim to a client radiologist (vascular interventional radiologist) where a spine and neck problem did not allow him to practice within his specialty but still permitted him to work as a radiologist. The courts disagreed because the insurance company initially listed his occupation as "radiologist" then later narrowed it to "vascular interventional radiologist". In essence, they could not deny benefits.
- There will undoubtedly be many cases defining what is: experimental treatment under health policies in the years ahead. Recent cases have "tested" policy meaning regarding alleged experimental breast cancer treatment, AIDs-related liver transplants, and bone marrow transplants. Clients have lost their claim for coverage on the basis of a legitimate denial based

on policy terms. Insurance companies have lost their cases where an exclusion about experimental treatment was not highlighted in a conspicuous manner.

- There are new cases developing in the area of language misunderstandings where clients have pursued claims on the basis they did not fully comprehend the matters at hand. In one instance, a client prevailed in her action against a health insurer because she understood little English and could not read the application. She relied on the advice of the agent but failed to disclose a preexisting condition. The courts determined that the insurance company could only deny coverage where an intent to deceive was found. In this case, they said there was no intent to deceive.
- Policy language often limits coverage for "accidentally sustained" injuries. Thus, cases have and are developing where attempted suicides have left clients permanently or severely injured. Since the injuries were self-inflicted, insurance companies have refused to pay. In one case, the insurer lost to a client who attempted suicide because "accidental" was NOT defined in the plan documents. In another example, the client also prevailed because the courts decided her treatment for an attempted drug overdose suicide was really treatment for her underlying depression. Further, the insurer was found to have misled her by not informing that mental and nervous disorders would not be covered if followed by an attempted suicide. Finally an insurer was prohibited from withholding a claim because the client had a "subjective expectation of survival", thus even though his injuries were self-inflicted it was still deemed an accident.
- The courts are leaning more and more to the proposition that tenants are implied beneficiaries under a landlord's policy.
- Within the last 20 years, the insurance industry introduced environmental impairment liability insurance (EIL) in an effort to provide pollution coverage for events, the industry deemed not to be covered by the more well-known comprehensive general liability policy (CGL). A very important distinction between these coverage's is that EIL policies are claims-made policies, while CGL policies are occurrence-based. The introduction of EIL insurance provided clients an alternative that was broader than CGL coverage in some respects, while narrower in others. For example, the insurance industry's position is that EIL insurance affords coverage for the gradual release of contaminants that, according to the carriers, would now be covered under typical CGL policies. On the other hand, as discussed above, claims under an EIL policy must be made during the policy period.
- One issue that continues to surface is the relationship of EIL coverage to other insurance purchased. For example, assume a company purchases both primary CGL insurance and EIL insurance. The question then arises whether the EIL insurance is primary coinsurance or excess to the CGL. The courts have ruled that the EIL was indeed excess coverage, however, there could be cases where EIL, if purchased alone, could be the primary insurer for environmental liabilities.
- Despite the fact that policies have been written as "All Risk," insurers continue to deny contamination claims based on policy exclusions.
- People have an unusual ability to acquire the problems and illnesses of others. Most "sick building" illnesses are found to be psychologically based rather than rooted in fact.
- The removal of asbestos continues to be a major source of conflict between clients and insurance companies.
- New standards require property owners who are selling or renting real estate built prior to 1977 to disclose any known lead-based paint or lead hazards. Experts believe that the next wave of lawsuits will result from these disclosures and potential client illnesses, real or not.
- On the heels of major hurricanes and earthquake, claims are surfacing concerning business interruption where clients have been forced to close stores and businesses incurring major

damages. A major issue that occurs in these cases is the determination of income. Most policies include a clause similar to this: "In calculating your lost income we will consider your situation before the loss and what your situation would probably have been if the loss had not occurred".

Suitability Beyond Insurance

The most important advice that financial experts give their clients concerning insurance is to buy insurance that really insures. The meaning behind this advice is that insurance can fail to insure for many reasons. Likewise, in some cases, insurance is simply not available. The purpose of this section is to explore how and why you need to help prepare your clients for these contingencies. This is a new area of planning that few agents practice. However, it can also be the most critical service you offer.

The Need to Look Beyond Insurance

Risk is a fact of life to be constantly analyzed and managed. Unfortunately, the time most people devote to this process is less than the time they spend planning a summer vacation. Therefore, who assumes the role of unofficial "risk manager" preserving possessions and family security? Insurance agents.

Like it or not, you are in the asset protection business. However, just how far can you expect your product (insurance policies) to go? Every agent knows that insurance has its limitations. There are times when clients are underinsured; there are clients who cannot be fully insured; and there are times when insurance simply fails to insure. Add to this a bevy of carriers, who withdraw or are unwillingly forced from the marketplace, a few insolvencies here and there, and you know why a growing band of attorneys and financial advisers are starting to look beyond insurance; supplementing insurance coverage with multiple legal strategies.

The next time you are assessing a client's "real" need for coverage, consider the following possibilities; all of which point to the need for "back-up" protection:

- The need for a protection structure which can be used as a replacement to insurance when premiums rise beyond a client's ability to pay.
- The need for a protection system that can supplement current insurance, covering gaps in protection like punitive damages or an underinsured health condition.
- The need for a protection structure that will become a backup for times when, for whatever reason, a lapse in insurance coverage occurs.
- The need for a protection structure as back-up when an insurer fails to pay or becomes insolvent
- When coordinated with estate planning, the need for a structure to protect inheritances and estates from frivolous claims and plaintiff attacks.
- The need for a structure to protect business and property owners from new and exotic environmental liability which may be excluded by their insurance or entirely unknown by present standards.

Few would argue that when clients are provided safe, appropriate and sufficient levels of coverage, insurance is the world's most efficient asset protector (a first line of defense). Today, however,

insurance by itself may not be the sole solution to protecting all assets because there are pressures at work, both legal and moral, that go beyond the resolution of good coverage.

It Costs More

It costs a lot to live today and it will cost a lot more tomorrow. There are many rules of thumb you can use to gauge the amount of life or medical coverage needed to cover loss of life or a major health condition. Will the \$250,000 life policy you sold last month leave enough to cover an additional eight years of medical school for the surviving dependent who suddenly finds out he wants to be a doctor? Will the health policy you delivered this morning cover new treatment options that might be considered “experimental” today, but standard procedure years from now? If not, there will be a huge coverage shortfall. How about the long term care policy you sold to a middle-aged couple. Will the \$92 daily nursing home care coverage do any good when inflation has bumped the cost of nursing homes to \$250 per day in 20 years? All of these examples are possible outcomes that you or your clients cannot anticipate; or, perhaps you did but the cost to cover them is not currently affordable.

Expanding Liability

The idea of using and needing additional methods to replace or augment insurance coverage has more chance to grow today than ever before. There are many areas and ways by which your clients are exposed to liability.

Despite your best efforts to limit a client’s financial and legal exposure, you cannot insure that policy limits will be breached or, by exclusion or technicality, completely fail. Furthermore, our country’s expanding liability policy almost guarantees that along the way you will miss something. Just think about the thousands of legal decisions each year based on precedent.

Cost of Defense

Just as important as expanding liability is the high cost of defense. A single mistake or accident that exceeds policy coverage can bankrupt a client. And, in cases where punitive damages are involved, there may be no coverage at all.

Deep Pocket Pursuit

People work the first half of their life to build an estate. During the last half, they are constantly worrying about someone trying to take it away from them. It is called “deep pockets” and it is the single greatest reason that people are sued. The question for your client is whose pocket it should be: theirs or the insurance company.

Asset Protection Planning

Better Client Protection or Lost Insurance Sales

Some may think of asset protection as “doomsday planning”, but every agent who has spent time in the business has a file on cases where expected coverage was lost or reduced due to limits, exclusions, warranties, preexisting conditions or any one of the reasons presented above.

Attorneys who routinely sue agents and insurance companies also have a file. But their cases are different. They feature smart and financially secure people who dutifully purchased insurance yet lost everything over a technicality or unforeseen claim beyond the scope of the policy. Seeing problems like this day after day, it is no wonder that some in the legal profession may have a hard time advising a client to "insure up". Rather, they are encouraging their clients to supplement basic insurance coverage with legal entity planning or, more simply put, asset protection.

While it doesn't appear to be a watershed, a limited number of insurance sales will likely be lost to asset protection planning. Then again, there is cause to consider that both insurance and asset protection are closely linked in providing a higher level of client protection. Knowing this, it may serve the client's best interest for an agent to associate with a competent asset protection attorney and know when to refer.

Legal Protection Theories

There are as many legal techniques that form the basis of asset protection as there are forms of insurance. The nucleus of these strategies, however, is focused on specific principles of legal theory. Here are a few to consider:

Asset Protection and Suitability?

Insurance agents are in the risk business, but there is nothing that says you must be responsible to cover all your clients' risks. However, is the product you are providing truly suitable if it still leaves our client exposed?

The idea of agents understanding and informing clients about additional measures beyond the scope of insurance is more than you are required to do. From an ethical standpoint, though, it demonstrates your willingness to suggest possible solutions (carried out by professionals who can implement them) beyond the limits of traditional coverage.

Free Alienability of Property

Our common law system favors the free alienability of property. In essence, this theory concludes that one who is free from creditor concerns is absolutely free to dispose of his property as he sees fit. This may include gifts to children, a spouse or a transfer to a trust. Clearly, asset protection planning is not an excuse to defraud creditors or evade taxes. Furthermore, fraudulent conveyance laws generally protect present and subsequent creditors from transfers of assets made by a person who is or foreseeably will become their debtor.

In essence, asset protection should be viewed as a vaccine, not a cure. And, like a vaccine, it should be administered before a legal problem arises.

Whole vs Sum of the Parts

One of the basic premises of good asset protection is the legal assumption that "the whole is worth more than the sum of the parts". This issue takes on more meaning with the knowledge that most asset protection planning involves the intentional "breaking up" of large ownership blocks into much smaller blocks, each with its own title and life. The force and effect creates a smaller "target" for a plaintiff or large creditor to pursue.

It has long been a fundamental legal tenet that small, individual ownership can lead to better protection of assets because a third party interested in laying claim to a client's assets will consider a fractionalized interest to be worth far less than a whole.

The common sense of this issue prevails: A creditor or high ticket insurance claimant, will factor in the cost, time and effort needed to force the sale of a single block of assets, under one ownership, in contrast to the much higher cost, time, effort and delay to retrieve multiple, variously titled assets. Further, in the case of some fractionalized assets that have been planned properly, there is no hope of the third party actually acquiring the asset. Rather, he would have to settle for the right to any income or benefits that might accrue from the fractionalized interest.

For most, the thought of being in business with other fractionalized owners who are, for the most part, at "odds with the third party", will be a distressing issue to overcome. In such cases, third parties may be completely discouraged from pursuing such an action. This is an important element of asset protection to keep in mind when studying the forms of ownership that follow.

Choice of Governing Law

In the United States, individuals generally have the freedom to select the law that will govern a business transaction. Examples include the use of Delaware or Nevada corporate law. Choice of law principles likewise allows a grantor of a trust to set up a trust that is governed by the laws of his or her home state or any other state. Taken further, there is no reason to limit one's choice of law to a particular state, the fifty states or any one foreign country when a world of governing laws is available. Factors to consider when choosing a governing law include the tax laws of the jurisdiction, whether laws are more favorable and protective, the political and economic climate of the jurisdiction, language barriers, telecommunication facilities, etc.

Free & Clear vs Encumbering

The old school thinking of owning "free and clear" is not always the best way to protect assets. By owning property free and clear, one is exposed to the potential for a large loss. In the case of real estate, a large earthquake can demolish property. Similarly, a sizeable judgment from a lawsuit can take property away. Some asset protection attorneys suggest encumbering or highly leveraging property (loans) to such an extent that a creditor will lose interest in pursuing it.

Conventional Forms of Protection Are Losing Ground

The new school of thinking is that traditional methods are not working like they used to. The corporate veil is seemingly more pierceable than ever. Further, the concerns with insurance coverage exist on three fronts: insolvency of the carrier, the willingness to continue coverage and exclusions such as punitive damages and gross negligence of associates.

Problems With Legal Entity Protection

Most asset protection programs involve the use of "holding entities" designed to isolate liability and thus contain exposure. Of course, good attorneys and financial advisors will admit that these measures are not foolproof. And, critics also point to volumes of law known as fraudulent conveyance

which can void a transfer of property if it is done without adequate consideration and with intent to avoid creditors.

Fraudulent Transfers

An example is a situation where a person hastily transfers title of a property to another family member to avoid creditors. This is not the ideal form of protecting assets. In fact it is called the "poor man's asset protection". Creditors are usually able to prove that a "fraudulent conveyance" occurred. Or, courts determine that the debtor failed to cut the strings by retaining benefits or control over the property. In either case, the creditor may proceed against the debtor and void the transfer of property.

For this method to have a chance, it must be used in the true context of "gifting" and be consistent with goals of the client (planning for college or an estate). The intent should be to have little control over the gifted asset. Broadly speaking, a fraudulent conveyance is defined as a transfer of property without adequate consideration and with the intent that the transferee will hold the property for the benefit of the transferor, returning it when requested, so as to defraud creditors who could otherwise seize the property in payment of their debts.

If a transfer is found to be fraudulent, it can be made "null and void" by a court of law. In essence, the law is not so naive that it will allow a person to avoid the payment of legal debts simply by making a "gift" of his property to another family member or a friend. Fraudulent conveyance laws protect present and future creditors against transfers of property made with the intent to hinder, delay or defraud them.

Creditor Access

Besides suspicious transfers, creditors have many opportunities to seize or access property and/or income based on the client's existing holding entity. Following is a short list of their rights by the type of ownership entity:

Joint Tenancy: There are many ways that creditors can reach a joint tenancy. In the case of a dwelling, a creditor attempting to reach the interest of a joint tenant can cause only the interest of the debtor to be sold. This compares with community property in that the creditor can force the sale of the entire dwelling to satisfy payment. For most other property, the general rule is that the creditor can acquire the interest of the debtor.

However, if the debtor is a joint tenant, the creditor forces an end to the joint tenancy and he or she becomes tenants in common with the remaining joint owners. In essence, holding title as joint tenants carries little creditor protection since creditors can attach a jointly held interest and petition the court to "partition" or divide up the property. If it is property that cannot be divided, creditors can order it sold to receive the debtors share.

Tenancy in Common: In the case of a dwelling, a creditor attempting to reach the interest of a tenant in common can cause only the interest of the debtor to be sold. This compares with community property in that the creditor can force the sale of the entire dwelling to satisfy payment. For most other property, the general rule is that the creditor can acquire the interest of the debtor. And as a tenant in common, the creditor can force a sale of the common asset. For this reason, it is important to select co-tenants who appear to be relatively free from financial problems

Community Property: The general rule is that community property is liable for debts of either spouse during the course of the marriage. Obligations incurred prior to the marriage or after a separation or divorce are consistently treated as the separate obligation of the spouse incurring the debt. Whether a spouse contracts for individual benefit or for the benefit of the community property is irrelevant. A creditor's ability to reach marital property is not effected by the purpose for which a spouse contracts.

If a debt, that is a joint obligation of a husband and wife, the community property together with the separate property of each spouse will be liable for the debt. A spouse who pays a single payment on behalf of the other spouse is said to have granted apparent authority to the other spouse to contract joint debts. The spouse who paid the bill may be held liable for subsequent debts incurred by the other spouse. A spouse who wishes to avoid such joint liability should make clear to the other spouse and any creditors that said spouse incurred this debt and acted without his or her authority or consent, or that the payment being made on behalf of the other spouse does not constitute authority for the other spouse to make future contracts that might obligate the paying spouse.

Partnerships: In general, the assets of a partnership are not available to a creditor of a partner on a personal debt of the partner. In practical terms, a creditor must only look to the debtor's share of partnership proceeds after the partnership has been dissolved and debts of the partnership paid. Alternatively, the creditor can look to attach the debtors profits and surplus from the partnership. This is called a charging order. It does not make the creditor a partner.

The charging order is intended to protect partners of a partnership that having nothing to do with the claims of creditors of another individual partner. A charging order is obtained by the creditor by making application to a court which then charges the interest of the debtor partner with payment of the unsatisfied amount of the judgment. The court may then or later appoint a receiver of the partner's share of the profits, and of any other money due or to be due him from the partnership.

If a charging order fails to be an available remedy, the courts have allowed the foreclosure sale of a partner's interest. At a foreclosure sale, only the partner's interest, not specific assets of the partnership, are sold. It is unlikely; however, that a partnership interest will bring a high price from third parties. If the creditor becomes the purchaser, and until the dissolution of the partnership occurs, the creditor will still be entitled to only receive the partner's profits.

Corporations: In general, creditors of the corporation can proceed only against the assets of the corporation and not ordinarily against the stockholders, officers, directors, agents or employees of the corporation. Exceptions to the above rule include where parties in the corporation have personally guaranteed some form of corporate obligation; where employees of the corporation have been negligent or have committed a wrongful act; where officers have not paid withholding taxes or similar taxes; where specific fiduciary violations can be determined.

Legal advisors are split on the issue of creditor rights against an incorporated sole practitioner. Some assess the "key person" rule in support of complete liability. Others argue that many lawsuits are derailed simply by the existence of a corporation. In many instances, the obstacles that must be hurdled to gain access to a debtor's partnership interest help shield a partner from all but the most determined creditors.

Limited Liability Companies (LLC): In an LLC, no one has personal liability for the debts of the partnership. All members of the LLC are liable to creditors only to the extent of their investment in the company

Trusts: In general, unless there are restrictive provisions in the trust spendthrift verbiage, a beneficiary's interest may be attached by his creditors or the beneficiary may sell his interest.

Creditors have also gained access to trust assets when the following conditions exist:

- The trust was funded as a result of a fraudulent conveyance
- The settlor of the trust retained too much control over trust assets
- The settlor retained too much of an interest in the trust
- The trust is illusory (trust is non-existent or a sham)

Exemption Planning

Exemption planning takes advantage of known "safety nets" already built into the law to help place certain kinds of assets beyond the reach of creditors. Most exemptions must be filed or claimed. If not, they are considered waived.

Civil Codes: Certain civil code sections offer exemption protection from creditors. They might include payments made for child support, spousal support and family support.

The Homestead: Homesteads are claimed on the principal dwelling of the debtor or the debtor's spouse. A declaration of homestead can only be made for a residence that is real property, not a houseboat or mobile home. This exemption may also be carried over where the proceeds from a formerly homesteaded dwelling are used to purchase a new dwelling within six months.

Personal Property: There are many articles of a personal and business nature that are exempt from creditors. A partial list includes:

- **Personal Possessions** Items such as health aids, jewelry, household furnishings (appliances, clothing and other items determined to be "ordinarily and reasonably necessary"), cemetery plots and motor vehicles may be excluded up to statutory limits.
- **Business Property** Tools, equipment and vehicles necessary to earn a living are exempt up to statutory amounts.

Life Insurance & Annuities: Both are exempt without filing. This means a creditor cannot force a policy holder to cash-in his policy. However, a debtor can be forced to borrow against the policy.

Health Insurance: Benefits from a disability or health insurance policy are exempt without filing (does not apply if the creditor is a health services provider).

Retirement Plans: In general, state laws protect most private or public retirement plans, IRAs and Keoghs from creditor claims unless they have exceeded their contribution limit or are needed for child or spousal support.

Personal Injury or Wrongful Death Damage Awards: Most are exempt to the extent they are needed to support the debtor and his family.

Bankruptcy: Filing bankruptcy is another method of exempting assets from creditors when necessary. It is important to note that there are federal and state bankruptcy codes. A federal filing

alone may not exempt debtors from state creditors. Well known types of bankruptcy filings include: Chapter 13 allows an individual under court supervision and protection to develop and fulfill a plan to pay his or her debts in whole or in part over a three year period, but it can last another two years. Chapter 11 is a version of Chapter 13 for businesses. Chapter 7 is a complete discharge of debts. Assets are liquidated to satisfy creditor claims.

Miscellaneous Exemptions: Paid earnings, Veteran's benefits, unemployment benefits, workers' compensation payments and college financial aid are exempt.

Medicaid Planning: A huge portion of our senior population has been caught "off-guard". Their longevity combined with escalating costs of long term care has created a need to try and capture the benefits of Medicaid through exemption planning. If they don't, a reasonable stay in a nursing home could impoverish their entire estate. It is a small wonder, then, why these people have turned in record numbers to lawyers and financial advisers to find Medicaid loopholes: ways to divest themselves of income and assets in order to qualify for Medicaid.

The process by which medical and nursing home care reduces a person's assets is known as spend down. In the case of Medicaid, some have referred to it as the "path to poverty". In essence, a person can't get assistance from Medicaid until virtually all assets are depleted. Certain assets are considered non-countable or exempt. They include:

- A house used as a primary residence.
- A care for transportation to work or medical services
- A wedding ring
- A cemetery plot
- Household furniture
- Cash surrender value of life insurance under \$1,500
- Real property if it is essential for support (land to grow food) or it produces income for one's daily activities.

Assets that are countable vary from state to state. The general rule is, if the principal of the item can be accessed (even if it cost a penalty to get), it counts as an asset for Medicaid purposes. Here is a short list of what counts:

- Cash, CD's and money market accounts
- Stocks, bonds, mutual funds
- Treasury notes and treasury bills
- Vacation homes and second vehicles
- Cash value life insurance and deferred annuities
- Revocable living trusts

Medicaid rules do not also require the immediate impoverishment of a spouse. But, the limits of what can be kept may mean a lower quality of life than what he or she is accustomed to living. In addition to exempt assets like a house, car and burial plot, the amount a spouse can keep varies from state to state.

In addition to asset criteria, there are guidelines for income. Generally speaking, for a person to be eligible for Medicaid he must spend all his income -- Social Security, pensions, interest, dividends,

etc. on nursing home care before Medicaid helps. In other states, the income restrictions are severe. Income is “capped,” even if all assets are “spent down” and even if this income doesn’t cover the cost of the nursing home. All of these guidelines and limits are a clear reminder that Medicaid benefits are supposed to be for low-income individuals.

Offshore Protection

The most aggressive protection strategies involve the use of foreign trusts, offshore corporations and offshore banking. Certain foreign jurisdictions do not recognize the judgments of US Courts. To reach assets held offshore it may be necessary for the creditor to retry the claim in the foreign jurisdiction. This would require hiring local attorneys and have witnesses, exhibits and other evidence be presented in the foreign court.

The costs associated with such an action may deter a creditor from pursuing the debtor further. One method of obtaining this protection is through the use of a foreign trust. Typically, the trust is located in a jurisdiction with laws favorable to judgment debtors. This means that a very short statute of limitations for fraudulent conveyance and a very high burden of proof for creditors to overcome. A duress clause is added to the trust, which makes the trust irrevocable in case of a lawsuit or threatened asset seizure. In the event that a creditor attempts to have the foreign court assert jurisdiction over the trust, a clause in the trust agreement provides the power to move the trust to a new jurisdiction.

Additional protection can be obtained by creating an offshore corporation. This corporation would achieve greater confidentiality and protection through the use of nominee officers, nominee directors and bearer shares. The corporation would hold title to bank accounts, brokerage accounts and other investments. The bearer shares would be controlled by the offshore trust. The offshore corporation would typically be formed in a jurisdiction other than the location of the foreign trust.

Offshore bank accounts are another method of using offshore protection. Accounts are typically opened in a country with strict bank secrecy laws and with modern communications and financial facilities for quick transferability. Many of these accounts can be linked to time deposits, debit card services, even financially secure mutual funds, and other securities.

Despite all the advantages that offshore protection appears to offer, it is not cheap. Only the most sophisticated and wealthy can justify these strategies. Properly implemented, however, an offshore structure can result in the most comprehensive and effective asset protection available.

Multi-Entity Protection

Asset protection professionals have discovered that, like insurance, there are many approaches to legally solving a client’s exposure. Offshore trusts, the subject of the last section is one option that can represent an extremely strong defense. For most, however, more affordable and manageable stateside techniques, using a multi-entity approach, are gaining favor. The multi-entity planner’s arsenal may consist of a combination of two, three or four of the entity methods to achieve added wealth protection in conjunction with and beyond insurance.

A coordinated approach can have, as a goal and outcome, many advantages:

- The preservation of assets from liability claims
- The lowering of the taxable value of an estate

- Reduction of current income tax liability
- Facilitate charitable gifting while keeping a legacy intact

Following are the entity structures involved:

The Limited Liability Company

The Limited Liability Company (LLC) is a hybrid business entity which has similar characteristics to both a Corporation and a Limited Partnership. The LLC is formed by at least two partners which can be any combination of one or more individuals and/or one or more legal entities. An LLC is structured much like a Limited Partnership in that the Managing Member controls the financial organization of the company much like the General Partner of a Limited Partnership. The Members are the silent business partners who have no control over the management of financial affairs of the company but have a right to distributions (on an annual or other basis) of any income or loss of the business.

From an asset protection standpoint, the LLC is the recommended way to operate a business (Note: Businesses requiring professional licenses cannot use LLC's, but can use a related statute called a Limited Liability Partnership, (LLP). The reason for this is that you, as the business owner, will not be personally liable for any of the debts or obligations of your business. Therefore, a catastrophic lawsuit or IRS tax lien will not necessarily expose any of your personal assets to the liabilities of the business.

Corporations

The most traditional way to operate a business in America is to structure your business as a Corporation. Essentially, the Corporation is a business entity, which is formed by filing Articles of Incorporation with the State in which your business is operating. The Incorporator who files your Articles of Incorporation forms the Corporation. Thereafter, an original Shareholder Meeting is held and a Board of Directors is selected. Thereafter, the Board of Directors selects the Officers who will actually operate the day-to-day operations of the company.

The downfall of the corporate format in some states is that the courts have indicated that if it is inequitable for the business creditor, they will not allow the corporate "veil" to protect your business or personal assets for your creditors. In essence, then, if your Corporation is sued or has an IRS problem, not only are all of your business assets completely exposed to the business liability, but your personal assets could also be completely exposed through the business liability.

The Family Limited Partnership

Asset protection planners say that the most preferred way to own personal after-tax assets is through a Family Limited Partnership (FLP). The FLP is a partnership format that requires at least two partners, like the LLC. The FLP generally will own all personal assets such as the family residence, stocks and bonds, mutual funds and other types of investments.

The general purpose of the FLP is to protect your personal assets from creditors. The FLP operates by virtue of the Uniform Limited Partnership Act which states that no creditor of yours can pierce your FLP and obtain assets held by your FLP. The only remedy that a creditor of the FLP has is to either receive an assignment or foreclose upon the individual/debtors Limited Partnership share utilizing a court procedure known as a "charging order". The charging order entitles the creditor to become an

assignee of the Limited Partnership share held by the debtor/partner. However, the great benefit of the Limited Partnership is that the General Partner (the client) does not have to make any distributions of income or other assets to any Limited Partner(s) through the course of the year.

In spite of the fact that the General Partner never has to make distributions, the Limited Partners are responsible for paying all the taxes of the partnership. Therefore, if a creditor obtains a charging order or forecloses upon a Limited Partnership interest, that creditor will have to pay their proportionate share of the taxes that they have foreclosed upon or have received via a charging order. In view of this unique capability, the FLP is the best asset protection tool that can be utilized to protect your assets.

An additional benefit of the FLP is that from an estate tax perspective, the IRS will allow discounts of between 15%-40% of the value of assets held in the FLP. This is the equivalent to reducing your estate tax exposure by that percentage upon your death. One of the most frequent questions about establishing family limited partnerships is how to unwind them. There are four basic ways to get assets out of the Family Limited Partnership:

- First, you may make pro-rata distributions from your Family Limited Partnership to the partners.
- Distributions will flow from the assets of the Family Limited Partnership to you or to your Revocable Living Trust, which would be recommended.
- Second, your Family Limited Partnership may pay a management fee to your Corporation. You determine the amount of the management fee and the terms of this fee can be very flexible. Income from that fee can be used to pay a variety of corporate expenses such as salaries, employee benefits, retirement plans, etc.
- Third, your Family Limited Partnership can loan money to you, your spouse, or other family members. Repayment of the loan is effectively repayment to yourself.
- Fourth, the Family Limited Partnership is totally revocable by you, your fellow shareholders and Limited Partners at any time. In the unlikely event that you would ever need to dismantle and revoke the Family Limited Partnership, the Corporation or the Trust, it simply takes unanimous vote by you and your spouse to do so. If this happens, title of your assets can be transferred back to your direct ownership without penalties or tax consequences.

The Revocable Living Trust

One of the most underrated legal documents that should be prepared for almost every family or individual is the Revocable Living Trust. Most people are not aware of the fact that if they have only a Will, or if they have no planning documents in place, that upon their death the probate court obtains jurisdiction of all their assets. Therefore, upon your death, your heirs would have to hire an attorney and file a petition in probate court to transfer your assets if you do not have a trust. The major problem with the probate process is that it takes anywhere from twelve (12) months to twenty-four (24) months to probate even a \$200,000 estate. In addition, there are probate fees which can range anywhere from 3% - 10% of the gross value of your estate. Accordingly, your heirs may end up paying hundreds of thousands of dollars to acquire title to assets that are legally theirs to begin with. In view of the above, the implementation of a Revocable Living Trust is an essential to any estate protection plan.

Multiple Entities Structuring In Action

A possible structure for both business and personal affairs might utilize a Limited Liability Company to operate an existing or new business. The LLC is for the most part a marketing company. It enters into contracts, employs individuals, and generally absorbs all of the liability of the business. The LLC is operated as a “shell”; it owns no assets. The purpose for utilizing the LLC as a shell company is that if the LLC has creditor problems or is sued then it can file for bankruptcy protection and a new LLC can be put in its place very quickly and efficiently.

A corporation might be utilized in the business context to handle all of the advanced tax planning for the business. The Corporation is usually filed in Nevada to take advantage of the fact that Nevada does not have state income or corporate taxes. A Nevada corporation can be set up to be either one of the partners of the LLC or can be utilized to own the equipment of the business and lease the equipment back to the LLC. The advantage of owning the equipment through the Nevada Corporation and leasing it to the LLC is that if the LLC ever has creditor problems it can file bankruptcy and the Nevada Corporation can reclaim the equipment and re-lease it to a new LLC. With respect to personal assets, it might be recommended that they be held by a Family Limited Partnership or Limited Liability Company as represented in the illustration.

What Does Multi-Entity Structuring Accomplish Taxes: With respect to the Limited Liability Company from which the business is operated, a possible illustration might be a \$60,000 per-year net income being paid to the LLC from the operation of the business. From the \$60,000 net income, \$25,000 per year would be paid to the client in the form of a salary. The remaining \$35,000 would be payable to the client through a beneficial distribution of income from operations on either a monthly, quarterly or annual basis. Without a Limited Liability Company, you would pay approximately \$9,180 in self-employment taxes based upon a \$60,000 per year business income at the current 15.3% self-employment tax rate as seen in the Figure. With the implementation of the LLC and a beneficial distribution of \$35,000 per year, you would save \$5,355.00.

Utilizing a Corporation in the business plan allows the business owner to receive a variety of benefits through the Corporation. The expenses involved in providing such benefits may be deductible to the Corporation and not includable in the taxable income of the client. These benefits include health, accident insurance, payment of unreimbursed medical and dental expenses, disability insurance and group term life insurance. In addition, automobile expenses can be reimbursed and/or paid through the Corporation. The Corporation can also reimburse and/or pay the entertainment expenses made on behalf of the client or the client’s family.

Pension Planning

Utilizing the corporate format, business owners can set up their own corporate pension plan which they can control as both the administrator and trustee. Therefore, the business owner or individual can contribute up to 15% of their net taxable income in said plan in any given year. Once the money is contributed to the plan, it grows tax-deferred but is completely taxable upon retirement.

The significant advantage of the Corporate Pension Plan is that the Internal Revenue Code allows business owners to borrow from their own corporate pension plan of up to 50% of the pension plan assets not to exceed \$50,000. This benefit allows business owners to contribute 15% of their gross

salary every year to a corporate pension plan and still allows said business owner to obtain a certain amount of liquidity with respect to pension plan contributions.

Alternative Pension Planning

Because of the problems above, Multi-Entity Planners offer alternative methods to better facilitate retirement planning. A highly recommended method utilizes various sections of the Internal Revenue Code (specifically Sections 79,162, 419A(f)(6), 501(c)(9) and ERISA) a specific insurance product and trust to overcome the problem areas indicated above. Alternative pension planning utilizes the concept of an Irrevocable Trust that receives all of the client's contributions. An employer's contributions are made to the Irrevocable Trust that is managed by a multi-billion dollar financial institution.

The client's business has no control over the Trust nor does the owner have any control over assets until the business owner decides to terminate his plan contributions and obtain it back on a tax free withdrawal basis! These pension plan alternatives allow business owners or other professionals to deduct 100% of their contribution as a business fringe benefit (expense) and receive 100% tax free withdrawals (income).

Estate Planning

Advanced Multi-Entity Structuring can provide the following estate planning advantages:

- The market value of your estate is lowered due to well-established principles granting discounts for lack of marketability and fractional ownership of an asset. You save up to fifty-five percent (55%) in estate taxes for every dollar your taxable estate is lowered through the implementation of a Family Limited Partnership. The Internal Revenue Service allows a minimum of a twenty-five to forty percent (25%-40%) discount on all the assets placed in a Family Limited Partnership. In a typical illustration, a \$2,000,000 estate could receive a 40% discount thereby excluding \$800,000 of assets from estate valuation. This \$800,000 exclusion would represent an approximate \$400,000 in estate tax savings to the heirs of the client.
- The estate plan allows for lifetime gifts of Limited Partnership interests to your children, grandchildren, other loved ones or charities while you maintain control over the assets. You can begin to reduce your estate by making gifts of fractional interests in your Family Limited Partnership which will further reduce the estate taxes due upon your death.
- This estate plan creates a way for you to manage your family assets. This is accomplished by setting up your Corporation as the General Partner of your Family Limited Partnership which will continue to manage your Family Limited Partnership despite the death or disability of any of the shareholders.
- This estate plan eliminates the need for probating your estate since a trust will transfer all assets to your children or grandchildren without court intervention even beyond the death of you or your spouse.
- This estate plan will clarify, prioritize and systemize your entire estate by (1) compiling all the essential information regarding your estate into one complete source; (2) reorganizing your financial paperwork into a single comprehensive file; and (3) transferring your diversified investment portfolio into a single, easier-to-manage asset - your Family Limited Partnership.

Asset Protection Plans

What happens today if a third party gets a judgment against you, your spouse or our business? Without implementing an asset protection plan, the majority of your assets are subject to seizure by third party creditors. Your creditors can pick and choose whatever they please in order to execute upon a judgment taken against either you or your business. Without an asset protection plan, almost all of your personal and business assets will be exposed to execution by a potential creditor. After implementing an asset protection plan, the majority of your assets is owned by a Family Limited Partnership and is safe from seizure by creditors.

Once your assets are transferred to a Limited Partnership format or a series of Limited Partnerships, the third party creditor cannot seize or obtain any portion of your estate. The creditor's only recourse is to obtain a "charging order" against your interest in your Family Limited Partnership or Business Limited Partnership. A charging order is similar to a garnishment of wages and requires that all distributions from your Family Limited Partnership which would have gone to you must now be paid to the third party creditor.

If you or your Corporation, as General Partner, decides not to distribute any income to the limited partners, then the creditor does not receive any money. At the same time, the creditor is responsible for all of the income tax responsibility or liability from the Limited Partnership. Assuming your Limited Partnership has taxable income and no pro rata distributions are made to the partners, the creditor becomes liable for "phantom income". In other words, the creditor must pay income tax on money earned by the Partnership but for which it did not receive any distribution. This unfavorable result dramatically improves your negotiating position against any creditors and helps to level the playing field. An asset protection plan developed by a professional provides the following asset protection advantages for your business and family:

- It shields your assets from the ever-expanding damage awards for personal injury and professional liability and it protects your assets from unfair or outrageous financial claims of judgment creditors.
- It insulates your assets from the effects of death or bankruptcy of your co-guarantors, co-makers of debts and fellow General Partners. With the asset protection plan, the problems of your partners do not become your problems.
- It provides an entity you control to be the beneficiary of the estate from which you anticipate an inheritance. Parents redraw their Wills or Trusts to leave their estate not to their children directly, but to their children's Family Limited Partnership so that the children's inheritance is protected from creditors.
- It provides protection for your legacy. If a son or daughter is in a high-risk occupation, you can implement an asset protection plan and thereby leave your children a Limited Partnership interest as their inheritance. This protects the assets of the parents while they are alive and passes on the same protection to their children.

Charitable Remainder Trust Planning

Although most people do not think of gifting assets to charities, the gifting of assets to a Charitable Remainder Trust is oftentimes an effective tax avoidance and asset protection. An advanced protection program designed by a multi-entity planner provides the following charitable advantages for your family:

- By transferring the family business, ranch, farm or other family asset into a Family Limited Partnership, a gift of a Limited Partnership interest to a charitable organization can be made while the family business, ranch, farm or other family asset remains intact to produce income for the benefits of all partners.
- As a Limited Partner, a Charitable Remainder Trust or organization has no control over the daily management of the Family Limited Partnership so that the family business, ranch, farm or other family asset may be operated essentially the same as before the transfer of Limited Partnership interest.
- The value of the Limited Partnership interest that is given to the Charitable Remainder Trust or organization can be taken as an immediate tax deduction on your current year's income taxes. In some cases, this may provide you liquidity that you previously did not have.
- By requiring the vote of all Limited Partners of the Family Limited Partnership and all the shareholders of the corporate General Partners, including the charitable organization, to liquidate the entities, you have optimized your potential to obtain a reduction in the valuation of your taxable estate.

Implementing a Multi-Entity Asset Protection Plan

Implementation of an Advanced Tax Planning and Asset Protection Program involves the transferring of title of your assets to various entities which include: Family Limited Partnerships, Business Limited Partnerships, Corporations and certain types of Trusts as well as Limited Liability Companies. The only limitations to the asset protection plan espoused by asset protection professionals is that the person implementing the plan must be financially solvent in accordance with general accepted accounting principles both before and after implementation, and the purpose of the transfer must not be to hinder, delay or defraud creditors.

Your net worth after implementing this program will remain substantially the same. The percentage of ownership in the Limited Partnership will not change the total amount of your net worth despite the fact that you now do not own any assets directly in your own name. However, you still control them through the connection of your Family Limited Partnership and your Revocable Living Trust.

Maintaining Control of a Multi-Entity Program

To maintain effective lifetime control over the any multi-entity program, you, your family members and other shareholders enter into carefully drafted agreements. These agreements include a Family Limited Partnership as well as various other contracts which bind all members and entities to vote for you as the person in charge. With respect to the Limited Partnership Agreement, since you act as General Partner, you control each and every movement of cash and other assets in and out of the Limited Partnership. You have total lifetime control over all of your assets utilizing these entities which cannot be disrupted even by death. As a result, the plan works much more favorably than the implementation of just one Trust Agreement or just one Corporation.

Is A Multi-Entity Asset Protection Plan Right For Your Client?

- Do they want to reduce the amount of income taxes they are paying?
- Do they want to leave the majority of taxable estate to your family rather than to the IRS?
- Do they want your assets to be preserved from expanding liability judgments?

- Do they want to make a charitable gift while keeping assets intact?

If they answered "yes" to any of these questions you should consult with a multi-entity planner.

A Final Word On Suitability

Getting to your client's true need and matching appropriate product is the heart of suitability conduct. However, the issues we presented in this section underscore the fact that finding a single need for a client is not enough. Surely, a serious conversation with a prospect about current challenges, unrealized opportunities, hassles and trends would uncover multiple needs. Therefore, you need to dig deeper with your questions and resist the urge to jump at the very first need your client revealed. In addition, you should always ask your client for clarification of their needs. Never assume without their input.

Product suitability is dynamic, not static. One "size" will not fit everybody and even for the same client it will shrink and expand over time. Therefore, the product you recommended 10 years ago may need to be replaced by another meeting new suitability requirements and the transformation in world events. Traditional methods of determining suitability will always play a role, but your ability to solve client problems and anticipate their needs is where you will earn your client's respect and business in the future.

Solvency Conduct

Like it or not, you are in the solvency business. Your job is to make sure that in your particular area of licensing you have done all that you can to prevent gaps in coverage and place your client's insurance with a reliable and secure company. Both are important to your client keeping his liquidity and assets. But, just how far can you expect your product (insurance policies) to go.

Every agent knows that insurance has its limitations. There are times when clients are underinsured; there are times when insurance fails to insure; and there are clients who, for a variety of reasons, cannot be fully insured. Insurance shortfalls or failures may surface in many ways. The source can be an agent's negligence in providing coverage or it can involve deeper issues such as inadequate or defective protection, coverage disputes, or the clear inability to pay (insolvency of the insurer).

In any instance, the result is bound to disappoint a client and cause potentially harmful exposure to personal assets as well as liability for the agent. Preferred solvency conduct would find you going to the lengths to recognize areas of client exposure you are unable to cover and referring out to professionals who can assist. This may involve supplemental coverage, readjustment of existing coverage, or even looking beyond insurance protection.

Coverage Shortfalls

Many Americans consider themselves dutiful to purchase and maintain insurance often buying multiple policies with varying features and limits. Occasionally, situations arise where a liability surfaces from an unanticipated source, beyond the scope of these features and limits, resulting in an insurance shortfall.

Such is the case where a breadwinner who bought a paltry \$50,000 whole life policy dies prematurely leaving a family with young children. Or consider a high wage earner who is the cause of a serious

auto accident that disables a neurosurgeon for life. Obviously a \$300,000 policy limit will not satisfy the surgeon's family and their attorney. When events like this occur the agent may find himself in the position of breaking the bad news or worse, liable for the shortfall. Sometimes, insurance shortfalls cannot be helped. After all, nothing in life is guaranteed to work out right every time, and unexpected, freakish accidents and events can occur without warning. Unfortunately, there are also instances where the coverage provided by an agent was significantly less than needed and the agent paid the difference. Then too, there are times when the coverage purchased or sold to a client exceeded what was needed in one type of insurance at the expense of another insurance coverage being underfunded and under covered: a high premium whole life policy leaves no monthly budget for health insurance, or an auto policy with low deductibles is chosen or sold instead of a higher deductible policy permitting the additional purchase of umbrella coverage. Where clients depend on an agent for multiple lines of insurance or simply because it's right to do so, agents need to consider the balancing of coverage to avoid critical shortfalls.

Coverage Disputes

In the midst of the litigation explosion, the stakes are high. Insurers are offering increasingly high policy limits, and insureds, who cannot secure coverage or who fail to be awarded coverage, risk losing a lifetime of assets. Given this scenario, conflicts between insured's and insurers and agents can easily gather steam. To further confuse the issue, the courts are constantly bending statutes while public attitudes produce more and larger plaintiff verdicts, this despite the fact that the industry operates under fairly standard contracts. In essence, there has never been a time for greater disputes in coverage.

One form of coverage dispute results when the agent fails to secure the promised coverage. The courts have found that when an insurance agent agrees to obtain insurance for a client, with a view to earning a commission, the broker becomes the client's agent and owes a duty to the client to act with reasonable care, skill and diligence. As seen earlier, agents have been sued for neglecting to secure the requested coverage, failure to notify the client that the insurance is not available, failure to forward premiums on policies which then lapsed, unintentionally omitting a specific type of coverage, providing unsuitable coverage, failure to properly bind the client and much more!

A more common form of dispute occurs when the insured and the insurance company simply do not agree on the interpretation of coverage provided. In practice, insurance coverage cases can be extremely complex. It is not unusual for these cases to involve numerous parties on both sides of the litigation. And, since policyholders usually buy insurance in many layers of coverage from many different insurance companies over many years, the number of companies brought into one insurance coverage case can be quite large. Coverage cases are also being consolidated by the courts where numerous policy holders and insurance companies have been found to be litigating coverage for the same underlying claims or addressing the same coverage issues.

In one instance, a group of independent environmental coverage actions were ordered to collectively resolve many common contract issues and cooperate in case management and discovery procedures simply because they were similar.

Legal Maneuvers

Attorneys at Work

Where coverage disagreements persist beyond an initial settlement, policy holders or their attorneys must begin the tedious task of processing documents and information relating to the insurance companies' interpretations and meanings of their policies. This often leads to a drafting history. The drafting history contains detailed records of the insurance industry's deliberations regarding policies and seeks the original meaning of policy terms and the manner in which they were intended to apply.

Courts have found such histories to be relevant and material, as well as filings made by insurance industry organizations on behalf of their members to state insurance departments and insurance regulatory agencies. Policyholders and their attorneys also seek underwriting and claims handling manuals written by insurance company experts that are used to provide guidance to insurance company employees. These manuals may demonstrate how the insurance company interpreted their policies. In addition, they may contain the company's official position on coverage, claims and loss control.

Many courts have ordered the production of such manuals and guidelines in the early stages of coverage cases. Another valuable source used by attorneys is reinsurance documents. Communications between an insurance company and its reinsurer can provide information on whether and how policies may apply to underlying claims and may offer assessment of the insurance company's coverage obligations. Access to reinsurance documents is a hotly contested issue in insurance litigation discovery, and some courts have refused access to such documents.

Disputes also lead to discovery of insurance company marketing policies by documenting company advertising and agent/broker representations, as well as how the insurer has handled other policyholders with similar coverage claims. Also investigated is the possible cause and effect of the insurance company's involvement in other coverage litigation.

Agent Records

A dispute between you and a client or you and an insurance company may require that you produce certain records and evidence. In your own defense, you can typically produce any file, note or electronic record (fax, e-mail, computer record) as long as it is something generated in the ordinary course of business. In other words, if you use as operations manual or stick "post-it" notes in you client files as standard operating procedure they are generally admissible. The test will be: Do you use these methods for every client?

An example might be a standard checklist of coverage's that you review with each client. If you can show that the client was offered, but refused a particular coverage on your checklist, it will be harder for clients to say they were unaware this coverage was available. Keep in mind that most parties to a claim will eventually gain equal access to your records. So, you want to keep all legally required records and be consistent from file to file. Also, never write derogatory comments about clients or the company in files. This could work against you in a trial or settlement.

Agent Cooperation

In a nutshell, most suits settle before going to trial so cooperation on all sides is generally desired. However, you should proceed with caution in any dispute or potential claim. Check with your errors and omissions carrier before discussing matters with clients or your represented companies. Do not try to settle the case; it could void your E&O policy. Do not make any promises to clients about resolving the matter or give them legal advice of any kind. Do not ever try to cover-up mistakes.

If your errors and omissions carrier wants to settle, it is usually best to agree. If you do not, you could be liable for court judgments that exceed the settlement already proposed by your E&O carrier.

Insurance Litigation

Although most insurance conflicts settle prior to trial, some disintegrate into protracted and unnecessary litigation. Some areas of specific conflict include the following:

Triggers of Coverage: The term trigger is merely a label for the event or events that, under the terms of an insurance policy, determine whether a policy must respond to a claim in a given set of circumstances. While this definition seems clear, "trigger of coverage" disputes have been raging for decades and have been the source of much confusion.

In a life policy, the trigger seems clear: death. However, issues, of whether the death was an accident or suicide within the incontestable period, are often up for debate.

Disability and health policies, however, have a higher propensity for dispute: What is a permanent disability? Are there waivers and if so, how long? What is a major illness? Has the deductible been met? Are there additional policy exclusions? In long term care policies, trigger of coverage is even more acute where a written declaration by a physician may be required to solidify a patient's inability to care for himself: the prerequisite for insurance benefits.

Policy language in most casualty policies center around three primary triggers of coverage issues. First, the carrier agrees to provide coverage for all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies, caused by an occurrence. Second, an occurrence is defined in the policies as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured..." Third, bodily injury is defined as "bodily injury, sickness or disease sustained by any person which occurs during the policy period", and "property damage" is defined as "injury to property which occurs during the policy period..."

The trigger is plain under these three policy provisions when property damage or bodily injury occurs during the policy period. But, the trigger question becomes somewhat complicated when a long period of time has elapsed between the act giving rise to liability. Examples include a leak or spill involving hazardous waste or exposure to asbestos or lead which may result in problems years later.

Most of the litigation concerning coverage for latent injuries have raised at least four different explanations of when damage occurs and thus triggers coverage. 1) The date of exposure to the toxic substance (the "exposure" theory); 2) the years in which the claimant incurred tangible injury ("injury

in fact" theory); 3) the date of manifestation of injury (the "manifestation" theory) and 4) the year in which damage "occurs" or "could have occurred (the "continuous trigger" theory). The continuous trigger theory has received considerable attention during the past twenty years surrounding property damage or bodily injury due to hazardous waste/environmental contamination.

In essence, the courts have generally ruled that casualty insurance policies can be triggered continuously from the initial exposure to the contamination to the manifestation of any injury, disease or damage of property. By far, most policy holder attorneys adopt a continuous trigger approach to litigation. Insurance companies continue to argue, sometimes to no avail, that insurance policies cover an "occurrence" and not a "reoccurrence".

Definitions: The following are terms that often become the focus of coverage disputes:

- **Bodily Injury** - bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.
- **Property Damage** - physical injury to or destruction of tangible property which occurs during the policy period. Loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period.
- **Occurrence** - an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.

Conditions: In addition to standard provisions and definitions, coverage is further defined in a conditions section where the duties and legal requirements of the insured and insurer are established. Typical conditions are the insurer's right to inspect, and the insured's duty to cooperate with the insurer and the notice provision. The notice provision is the most frequently litigated condition.

A sample notice provision might include the following language: "In the event of an occurrence, written notice containing particulars sufficient to identify the insured, the time, the place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company".

Some courts have relieved the insured of its notice of obligation unless the insured was in some way prejudiced or harmed by the insured's delay in providing notice. The insurance company usually has the burden to prove that it was harmed by the insured's failure to comply with the notice requirement.

Exclusions: There are many standard policy exclusions as well as those relating to high risk issues such as partial disability, pollution, nuclear attack, "owned property", aircraft and liquor liability. The purpose of these types of exclusions is to limit the policy coverage to contemplated risks only. The burden of proving that an exclusion applies generally falls on the insurer in coverage disputes.

Named Insured: The definition of a "named insured" varies from policy to policy: Some define it in broad terms, while others insist on a more narrow description. Often, standard policy formats will provide a "listing" which has resulted in legal conflicts where coverage was denied a party on the listing who is no longer associated with the primary insured. The burden to prove continued association is with the insured.

Assignments: Conditions of most standard policies prohibit assignments without written consent of the insurer. Such provisions are enforceable because they ensure that the risk the insurance

company agreed to insure remains the same. In fact, the majority of courts have refused to hold an insurer liable for an occurrence derived from a risk not contemplated by the insurer at the time the policy was issued. It is important to note, however, that prohibiting assignments does not bar the assignment of insurance proceeds.

Rules of Construction: The rules governing the construction of insurance contracts are usually the same as those for other contracts: the policy language is to be interpreted given its plain and ordinary meaning. If a court determines that an ambiguity exists in an insurance policy, it will look to any outside factors or evidence that may help determine the parties' intentions. Where an ambiguity is not capable of resolution, most courts have construed the ambiguity in favor of the insured.

Other courts have applied a "reasonable expectations" test and construed ambiguous policy language based on what a reasonable person in the position of the insured would understand the language to mean.

Duty to Defend: The prevalent view by the courts is that an insurer has the duty to defend an insured where the policy language gives the insured a reasonable expectation that the insurer will provide a defense. Standard policies employ language reading: "the company shall have the right and duty to defend any suit against the insured seeking damages on the account of bodily injury or property damage even if the allegations of the suit are groundless, false, or fraudulent".

Insurers maintain the position that they may be contractually bound to defend, but may not be bound to pay, either because its insured is not factually or legally liable or because the occurrence is later proven to be outside the policy's coverage.

Coverage disputes are likely to develop and do, when an insurance company attempts to shield itself from any defense of an insured whatsoever, or when it withdraws from an action after it determines there is no basis for recovery. Other conflicts center around whether an insurer must defend only against an action that is an actual lawsuit seeking damages or be required to defend against all claims which may result in liability. In general, courts assume a connection between the filing of a complaint and the triggering of a duty to defend by an insurer.

A PRP letter (Potentially Responsible Party), received by a client although not an actual claim, has also been interpreted by the courts to be a serious event that could, in fact, represent a new legal action against the insured. The duty to defend is typically established here, but not in the case of a simple demand letter which only exposes one to a potential threat of future litigation. If there is any doubt as to whether the facts give rise to a duty to defend, it is usually resolved in favor of the insured, but it is the insured's burden to show that the claims come within the coverage.

Claims related to acts of an insured in the area of crime, sexual misconduct, wrongful termination, contractual obligation, loss of profits or goodwill, have been ruled unacceptable ways to force an insurer's duty to defend.

Breach of Contract / Refusal of Coverage: Breach of contract claims typically allege that an insurance company failed to defend or indemnify the policy holder under terms of the insurance contract. To a great extent, public policy supports the policy holder in most breach of contract allegations in an effort to solidify the "strict enforcement of insurance contracts". This is why state insurance regulators will typically be involved or called upon to rule on an insurer's potential or actual violation of codes.

Many times, an insured is denied protection because the insurer knows facts which would defeat coverage. A majority of different courts have ruled that under such conditions, an insurance company is not bound to "defend" such claims simply because it cannot be bound to indemnify: the duty to defend can be disputed. Here, the insurer has the burden to prove that the facts of the insured's claim fall squarely within a policy exclusion.

Bad Faith: There is increasing judicial recognition that the relationship between an insurer and its policy holder is fiduciary in nature. Courts have compared the relationship of an insurance company to its policy holder to that of a "trustee for the benefit of its insured". Where an insurance company allegedly has violated its fiduciary duties owed its policy holders a bad faith claim could be appropriate in addition to any breach of contract action.

Choice of Law / Venue: Choice of law and venue, where to bring a suit, have become integrally tied together in coverage cases. There is general agreement that insurance coverage issues are state law questions even though most insurance policies do not contain any choice of law provisions. Courts, however, have also made venue decisions based on issues such as 1) the place where policies were contracted; 2) the location of the damage and/or 3) the principal place of business/residence of the policy holder.

Lost Policies: Some claims between insureds and insurance companies have developed over the inability of the policy holder to prove coverage by producing an executed insurance policy. If a policy has been lost or destroyed, the policy holder must satisfy two requirements to prove coverage.

- First, the policy holder must prove that the policy was, in fact, lost or otherwise unavailable by showing that he made a diligent search for the policy in all places where it can likely be found.
- Second, the policy holder must prove the existence and the contents of the policy by identifying the parties to the contract, the policy period and the subject matter of the policy. Secondary evidence includes any correspondence, certificates of insurance, claim files, management reports, corporate records, ledger entries, receipts, licenses and agent files and agent testimony. Coverage disputes also evolve around the nature of damages or hidden exposures such as:

Environmental Litigation: There are numerous actions pending in state and federal court concerning the interpretation of commercial liability policies and environmental claims. Much of the confusion was started by the insurance companies themselves when they first marketed the 1966 standard form Comprehensive General Liability (C.G.L.) policy which represented coverage for environmental hazards. Some companies went so far as to refer to environmental problems, in their sales literature and presentations, as a "hidden exposure" that policy holders should consider.

Agents were instructed to sell the new policy on the basis of its broadened coverage in the area of pollution which was then only a growing, but minor exposure. Since the 1960s, the Environmental Protection Agency (EPA) has contended with almost 300 million tons of hazardous industrial chemical waste leading to passage of the Superfund legislation which has obtained almost \$4 billion in settlements from waste generators, disposers and transporters of hazardous materials.

Similar pending litigation involves other forms of mass tort liability, including asbestos, DES and other substances. The generators, disposers and transporters of hazardous waste and product

manufacturers, installers and sellers faced with mass tort claims all turned to their insurance companies for coverage, and insurance coverage litigation often followed.

In response to a flood of litigation, the insurance industry began making adjustments. In 1973, certain terms in the C.G.L. policy were revised. For example, the 1973 C.G.L. policy defines "occurrence" as "an accident,, including continuous and repeated exposure to conditions, which results in bodily injury or property damage neither expected or intended from the standpoint of the insured." Obviously, an occurrence under the 1973 definition required exposure to conditions over a period of time. "Property damage" was also changed to read "physical injury to or destruction of tangible property which occurs during the policy period ... or, the loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period." Thus, compared to the pre-1973 contracts, "property damage" now requires physical injury to tangible property.

This distinction may be critical in certain hazardous waste cases and in asbestos property damage cases. In fact, courts have held that some insurers are not required to provide a defense in suits where the there was no covered "occurrence" or "property damage" as defined in the C.G.L..

In the late 1970s and early 1980s, a number of carriers made even more dramatic moves by changing the "pollution exclusion" clause in their policies from the "sudden and accidental" variety to what is called the "absolute pollution exclusion". Although there are several versions of this exclusion, the basic thrust of each is to exclude coverage if the omission or discharge was accidental or sudden. Since most hazardous waste problems are sudden and accidental, the absolute exclusion appears to exclude most pollution incidents.

A growing number of courts are siding with insurers where the absolute exclusion is in place. In these cases, most environmental exposure falls back to the insured and his own ability to cure the problem. The results can be devastating to a company, its owners and their respective estates. In more recent years, new court cases are again changing interpretations of CGL. Past court cases held that CGLs covered only those liabilities arising from torts. The new precedents now say that CGLs cover BOTH tort and contractual liability. Experts say that this decision has far-reaching negative effects on insurers across the country.

Excess Insurance Claims: With the increase in mass tort litigation, environmental litigation and substantial jury awards, excess insurance policies and the role of excess insurance carriers have received increased scrutiny. In general, the fact that a primary carrier owes duty to its insured is well known. With respect to an excess insurer, the courts continue to struggle with the origin of duty. In coverage disputes where the insured is bringing action against both a primary and excess insurer, the excess carriers sometimes moves to dismiss the lawsuit on the basis that the actual exhaustion of the underlying primary liability limits is a prerequisite to a claim under the excess policy.

Policy holders, on the other hand, argue that the mere potential that the underlying insurance will be exhausted is enough to justify a coverage dispute against the excess carrier. The courts have sided with each. Another area of dispute is the drop down: where an excess insurer "drops down" to provide insurance when the primary insurer has become insolvent. Courts are split on this issue, although a majority currently feels that an excess insurer is not obligated to drop down and provide coverage to an insured.

The court's determination is usually based upon the language of both the primary and excess insurance policies. In yet another decision, the courts have determined that the "trigger" of excess

coverage is the amount "indemnified", not the additional costs involved in defense nor punitive damages.

Business Insurance Disputes: In recent years, the number and variety of claims brought against business has increased significantly. In spite of this fact, many businesses have not given adequate consideration to the potential insurance coverage for these claims. As an example, businesses which face claims only against their directors and officers might tend to ignore the possibility of comprehensive general liability (C.G.L.) insurance coverage.

Likewise, when companies face claims of unfair business practices or statutory violations, they consider the bodily injury and property damage portions of their C.G.L. policies only, failing to consider the advertising injury and personal injury provisions, which may provide broader coverage, in one advertising coverage dispute, the court held that the insured was NOT covered by its C.G.L. policy because the insured failed to establish that its advertising activity caused the alleged injuries.

The insured was selling a product that "infringed" on a competitor suggesting that the relationship of selling and advertising were the same thing. Another court's rejection of coverage involved copyright infringement. Here, an insured distributed brochures that merely advertised copyrighted material for sale.

Directors and officers liability coverage typically insures the directors and officers directly and provides that the insurer will pay on behalf of or reimburse the directors and officers for "loss" arising from claims alleging "wrongful acts". Coverage is not afforded under this insuring agreement if the corporation is required or permitted to indemnify the directors and officers.

Coverage has also been denied for claims involving dishonest conduct, claims in connection with the Employee Retirement Income Security Act (ERISA), claims involving bodily injury, personal injury and property damage as well as claims involving seepage, pollution and hazardous waste.

Defenses of the Insurer

Much attention is devoted to the rights of policy holders. Insurance companies, however, have their own safeguards, which help protect their interests, but add to the growing list of things that can go wrong with insurance. Depending on the issue at hand, the result of having these built-in protections can completely void a policy or greatly limit its scope of coverage.

Defenses consist of legal tools and techniques that help an insurer initially determine pertinent aspects of the insurance risk for purposes of deciding whether to issue the policy and at what premium. After a policy is committed, additional policy conditions help the insurer "contain" the risk within the intended bounds of the contract. Over the years, a series of standard defense devices have evolved. These can be categorized as concealment, representations of the insured, conditions, warranties and limitations to coverage.

Concealment

The insured has the duty to disclose to the insurer all material facts that might influence a decision to issue a policy of insurance at all, or issue it at a particular level of premium. The holding back of information can, in some cases, constitute fraud by the insured and can render a policy void. In general, the rule on determining when a policy is voided lies in the issue of "bad faith".

If the insured withholds information that he knows would be necessary to the insurer in evaluating risk, the insurer has grounds to void the contract. Examples might include a life insurance policy where an insured has agreed to an examination by the insurer's physician but still fails to disclose a medical condition that is critical to the insurer's risk decision. The burden of proof as to fraud in concealment falls on the insurance company.

In some cases, courts have sided with the insurer in establishing fraud by "inference". An example might be discovered evidence that the insured had made a previous attempt to destroy the covered building. On occasion, the insured has won based on the argument that facts uncovered by the insurer were not material because it was not made a subject by the questions asked on the application even though most applications include a provision requiring the insured to represent that he or she has disclosed all material information.

Only when the insured conceals a fact in bad faith, knowing the fact to be material, will the policy be voidable. An example is a life insurance application which contains a question as to how many times the insured has been hospitalized and for various causes. If the insurer describes one hospitalization but fails to mention a second, the incomplete answer is considered material and grounds for avoidance of the policy. However, if the insured had left the answer blank or merely given a date without specifying the cause, the incompleteness would be obvious and not grounds for avoidance. The test is whether or not the reasonable insurer would be misled.

Once a contract of insurance becomes binding, the insured ceases to be obligated to disclose any material information. In the case of life insurance, for example, where there is an appreciable period of time between the submission of the completed application and the issuance of the policy, the duty of the insured to disclose new or forgotten material information continues. The duty to disclose applies only to facts, and not to mere fears or concerns of the insured about his health or the subject matter of the policy. There is also no requirement that the insured disclose facts that the insurance company already knows, or which the insurer has waived. Nor, is the insured required to communicate events that are a matter of public record such as earthquakes, forest fires.

Misrepresentations

A representation by the insured that is untrue or misleading, material to the risk, and is relied upon by the insurer in issuing the policy at a specific premium is considered a misrepresentation and grounds for avoidance of the policy, unless the policy is beyond the incontestable period. This is true even if the misrepresentation was made by the insured innocently, with no intent to defraud. A minority of courts, however, take a somewhat less severe position limiting or prohibiting avoidance where the insured's misrepresentation was not an intent to deceive the insurer.

Representations by an insured to an agent bind a contract because they are considered to be made to the insurer itself. However, a policy refusal or avoidance could occur when the insured has reason to believe that the agent will not pass information on to the insurance company. The insurer cannot void a policy based on a representation by an insured regarding an intention or future conduct unless it is made a condition of the contract.

An example here would be an oral statement by an insured that he will install a fire alarm at the premises. The insurer relies on this representation and reduces the premium but does not include an

express term in the contract regarding the alarm. On the other hand, a written commitment by an insured to install an alarm that is not followed can jeopardize the policy.

Many insurance conflicts center around materiality. A representation is considered material if it served to induce an insurer to enter into a contract that would otherwise be refused or issued at a different premium. The point where representations by an insured cause coverage problems; is where such representations are made with the intent to deceive and defraud.

The burden of proving a representation to be material falls on the insurance company. If a material representation is found to be substantially correct, or believed to be correct by the insured, the courts have not permitted a voidance or limitation of coverage. An example might be an insured indicating he has not seen a physician within the past five years when he has been to a doctor for treatment of minor and passing ailments.

Warranties & Conditions

The terms warranty and condition are generally used to mean the same thing - a representation or promise by the insured incorporated into the contract. A warranty or condition statement that is untrue and relied upon by the insurer at the inception of the policy can void the contract. A possible exception to this rule occurs in life insurance where an incontestable clause prohibits the insurer from voiding a policy after the insured has survived a given period of time: usually two years. Thus, a valid warranty/condition is a powerful tool for insurers.

In recent years, the effectiveness of warranties and conditions have come under fire. In fact, many statutes now place stiff definitions and limitations on warranties. One statute, for example, provides that all statements made by the insured will be considered to be a representation rather than a warranty unless fraudulently made. As previously discussed, it is much harder to void a policy for misrepresentation than for a violation of a warranty or condition. Another statute requires that the breach of warranty is a defense for the insurer only if it actually contributed to causing the loss, as opposed to simply increasing the risk. This is the most severe type of statute for the insurer, since even in cases in which the breach caused the loss, it is frequently impossible to prove the cause, e.g., a fire completely destroys a portion of a building.

Limitations on Coverage

Insurers over the years have attempted to control their exposure by tightening terms of the insurance contract. Adding personalized warranties and conditions is cumbersome and not always useful as a defense for insurers (see warranties and conditions above). Some courts, however, believe that insurers side-step warranties and conditions by creating numerous clauses that serve, instead, to limit coverage.

The reason insurers have do this is because many of the statutes which commonly limit warranty defenses, such as incontestability, contribute to loss statutes and increase the risk statutes, do not apply to limitations to coverage. There are several types of limitations that insurance companies can and do employ:

- **Limitations of Policy Subject Matter** — A homeowner's policy may cover most household possessions in general, but specifically exclude from coverage particular items like cash or coin collections. Likewise a health policy may exclude or waiver certain illnesses.

- **Limitations by Type of Peril** - A fire policy may except from coverage any loss caused by a fire resulting from lightening or earthquake.
- **Limitations on Proceeds Paid** - Casualty insurance policies frequently specify an upper limit of proceeds payable for any loss, as well as limiting the payment to the value of the insured's interest in the property damaged. Automobile policies generally fix the upper limit of coverage both in terms of maximum proceeds per person and maximum proceeds per accident.
- **Limitations on Period Covered** - Every policy will be specific as to the date of expiration, and in some cases, as with life insurance, will also specify a grace period beyond the date of expiration that insured's may make a premium payment. Also, the date of inception of a policy can be specified on the policy or can be subject to the occurrence of some event such as the payment of the first premium or delivery of the policy to the insured. A limitation on coverage can cause considerable conflict between insurer and insured.

One reason is the fact that in some instances, it is nearly impossible to determine from the wording of a clause whether it is a warranty or limitation. In response, the courts have developed two tests to distinguish the two. In one test, if the circumstance which is the subject of the clause is discoverable by the insurer at the time of inception of the policy, the clause will be classified as a warranty rather than a limitation.

Another test deals with risk. If a clause refers to a fact which potentially affects risk, but necessarily causes the loss, it is considered to be a warranty not a limitation. An example is a life insurance policy with a provision that excludes a death benefit while the insured is flying in a private plane. The insured can bring action to force payment of such a claim, even if the insured died of a heart attack while in a private plane. The flying merely increased the risk, but need not be the actual cause of death. Such a clause is considered a warranty. On the other hand, if flying in the plane was the cause of death, it could be interpreted to be a limitation that is better defended by the insurance company.

Settlement Disputes

Some forms of insurance, like life insurance, are generally settled with ease since the amount paid in the event of loss is fixed by the contract. Similarly, in the case of accident insurance, the proceeds are measured by a specific amount agreed to be paid for loss of a particular limb or faculty, or, as in the case of health insurance, by the medical expenses actually incurred. By far, most settlement disputes occur over property/casualty policies where the payment in the event of loss is determined by an amount up to the "actual cash value" of the property at the time of loss. There are two basic approaches which insurance companies use in an attempt to arrive at a mutually agreeable value: reproduction costs less depreciation and market value.

Reproduction Cost Less Depreciation

This measure is aimed at determining the cost of replacing the exact depreciated property that was lost. If this were the only option for insured's, it would represent an extreme hardship where, for example, the owner of a fifty-year old home that is destroyed would have great difficulty replacing it with a new building on the depreciated settlement, for this reason, replacement cost insurance is offered. Here, depending on the wording of the contract, the insured may be required to actually repair or replace the building in order to collect full payment.

The most pressing problem for insured's is to keep policy limits above the 80% of market value requirement. Insurance companies require policy limits above this level to assure adequate coverage

and keep premium levels high. Insured's may lose; however, if inflation and rising house prices cause the limit of coverage to wind up below the 80% figure at the time of loss, thereby nullifying the replacement cost provision.

Market Value

Items of commerce that are readily replaceable in kind (a warehouse full of books, shipments of grain) have a market value that is relatively easy to establish. In the case of income producing property such as office buildings, apartments or commercial buildings, market value is determined by a more detailed method using the capitalization of earnings. Disputes in this area usually require testimony of an expert witness who determines the rate of return on investment that a reasonable investor would require in investing in this type of property.

Failing Insurers

Today potential trouble spots and ideas for constructing new regulations to protect consumers are being unveiled at a fast and furious pace. The suggestions come from consumer coalitions, industry groups, auditors, state regulators and some members of Congress who continue to press for some form of uniform federal supervision of the entire insurance industry. At the center of attention are the issues of safety, solvency and agent due care: how to regulate, who will regulate, what the consumer will be promised and whose going to pay if something goes wrong.

Clearly, the insurance professional is at risk to know as much about his product and company than ever before. Recent and past problems are complex and visible and not limited to insurance companies. Most financial markets and many industries have changed dramatically especially in the last 20 years. Changes in financial institutions have resulted from events like information and communication technologies to substantial financial disasters among independents and insurance conglomerates alike.

Geographic and product boundaries for financial markets, traditionally, not a factor for insurance companies, have faded, and new products and services have blurred the distinctions between bank or thrift institutions, security brokers and insurance agents. A place once reserved to buy groceries, for example, may now be a convenient spot to deposit or cash a paycheck.

Further, with the Internet beaming financial and educational services to anyone who owns a computer, there is no indication that this era of change is over. On the contrary, financial markets and institutions will continue to evolve. The need to adapt to the increasingly competitive environment, new products, financial "heart attacks" and more has presented problems for many types of financial institutions: commercial banks, savings and loans, securities firms, and insurance companies.

As always, when things change or require restructuring, there is a period of adjustment accompanied by trial and error, financial stress and an increased likelihood of less than top performance or the threat of complete collapse. It happens to many kinds of companies (including property/casualty and life/health insurers). It is a fact of doing business and part of any free-market system. Multiple and prolonged insolvencies, however, take their toll.

The insurance industry becomes tarnished, and new consumer/political pressures expound. This, in turn, expands the burden on regulators, industry groups and the insurance professionals to correct the potential effects a major insurance failure may have against the public and the economy. In some

cases over-regulation and speculation result in panic or perhaps a "light trigger" that could catapult a seemingly secure company into the solvency spot light. During the 1980s, solvency paranoia was focused on the banking industry.

The insurance industry has had its bout with solvency wars. In fact, just the cast or suspicion of problems or a drop in bond ratings has put companies at bay or, in some cases, out of business. With rare exception, the insurance industry has enjoyed the comfort of consumer and regulator confidence throughout its history. Conservative marketing and investment practices in the industry scored high marks with a remarkably low rate of failure. Performance has periodically fallen below adequate levels, but generally not to a point that would jeopardize solvency.

In the few episodes that varied this trend, insurance regulators, insurance companies and industry groups like the National Association of Insurance Commissioners have appeared to provide appropriate regulatory responses. Recent episodes are no exception. Most of the major insurers that went insolvent are in the process of being rehabilitated by state regulators or private investors. It is doubtful that policy owners will incur material losses.

The Failure Rate

It is true that the decade of the 1980s and the early 1990s subjected the industry to higher levels of financial and market trauma than ever before. This period was marked by new records in sales and innovations. Fierce competition and increasing cost pressures became new problems in addition to outside influences like federal deregulation of financial services, higher interest rates, new financial instruments, expansion of tort liability, soaring medical costs, catastrophic claims, the entry of some inexperienced, small insurers and relatively poor investment results.

In a rather short time frame, the industry evolved from a conservative, mature business with stable elements and generous profit margins, to a business marked by higher risks and narrowing profit margins. A combination of these factors has also brought media and political attention and a definite erosion in consumer confidence. As this confidence declined, redemptions increased dramatically. At the same time, a major recession created financial havoc via junk bonds and plummeting commercial real estate values. The result: insurer failures.

The additional toll of many years of rate wars and dramatic natural disasters created even greater pressures on the property/casualty side of the industry. The federal government has published volumes on insurance industry abuses and made scathing comparisons of insurer problems and the huge banking debacle of the late 1980s. Actual statistics, however, tell a somewhat different story. For example, in 1989, the peak of the bank and thrift controversy, failures in that industry numbered over 500 institutions involving some \$130 billion in assisted mergers or closures. In the same year, which coincidentally seems to be the peak year for insurance company problems, the number of failed companies numbered about 40 property-casualty insurers and about 40 life companies with a combined total bailout of less than \$1 billion?

A 2001 Standard & Poors study uncovered fewer failures where only 56 companies failed (31 P&C, 17 health insurers, 5 life companies and three title groups). And, a recent Weiss Research found even more improvement with only 23 failures (20 P&C and 3 Life) in 2002. While no one should be happy with company closings, it is clear that insurance industry failures have and will not likely become another savings and loan fiasco; especially, since recent information seems to indicate a cycle of declining failures.

What Do the Problems Mean

Many of the pressures described above have already "vented" in the form of a rise, in the latter half of the 1980s, in a number of insurance companies failing, at least by certain regulatory standards, and those requiring formal action. Most of the underperforming activity, until only recently, was confined to companies writing between \$6 million and \$12 million in premiums per year and assets of between \$20 and \$40 million: small companies in the world of insurance.

According to many industry professionals, however, the typical American insurance company is in no way facing the kinds of risks faced by major company breakdowns like Executive Life, Mutual Benefit Life and others. In their opinion, the bulk of the industry has pulled through a tough economic environment and remains financially responsible. Most insurers are generally well capitalized, relative to other financial institutions, and are restructuring assets to meet new solvency standards, merging with stronger insurance and non-insurance companies and still conservative.

Whether these measures are enough to weather the economic storms, natural disasters and terrorist activities remains to be seen. The industry is typically optimistic. The independent agent, however, continues to walk a tightrope between clients who demand a "close to perfect" recommendation, an industry that is reeling from some major restructuring, aggressive competition and regulators who seem to have their own agenda. Through it all, no one has decided on a uniform system to determine safety and solvency and what role the agent will play. Any practicing agent should obviously stay close to this developing arena since you could be held responsible for recommending an insurer who later fails.

What Can We Expect In The Years Ahead

During the last half of the 1980s industry failures filled the spotlight. During the 90's, poor profitability due to severe price competition and continued underwriting losses became the problem. For the new millennium, other problems in the industry have been brought to surface like deceptive sales practices, misleading illustrations, national health care, asset risks, the adequacy of the state guaranty system, private rating service deficiencies and certain industry tactics used to "shore up" balance sheets. This negative exposure accelerated political investigations which have and will continue to result in new regulatory pressures. In addition, new troubles from major growth in class-action filings are disturbing. For the meantime, most insurers have been fairly successful in stabilizing their financials (particularly capital surplus) through aggressive cost containments and the "bulk sale" of selected assets.

Some experts believe that company managers are overcompensating, building surplus beyond reasonable levels in response to new or proposed risk based capital rules. While this will help companies meet new regulatory quotas, future earnings will decline, as potentially profitable acquisitions are by passed and the development of new product lines is placed on the back burner.

Some believe, in the long run, insurers will be legislated out of their ability to make any investment risks. Since investment profits play a major role in surplus, this could leave the industry at a major disadvantage to cover future liquidity problems. A major turn of events or more catastrophic hurricanes or floods could again push many insurers over the brink.

Further, the insurance industry position as a major source of capital for real estate and bond markets will be diminished or lost. The convergence of financial markets and the enactment of the Graham-Leach-Bliley Act (GLBA) in 1999 ushered in another phase in the evolution of insurance markets and their regulation.

GLBA significantly eased Depression-era financial regulations (the Glass-Steagall Act of 1933) that hampered the ability of banks and other financial institutions to provide a full range of financial services that crossed artificial organizational barriers. The new law permits financial services companies to merge and engage in new business activities and the cross selling of financial services and products, while attempting to address the regulatory issues raised by such combinations. Insurance and non-insurance financial entities are developing and implementing various strategies in reallocating capital and serving consumers in an environment where an array of financial products compete as substitutes or are marketed as complements.

Future Operational Changes

The biggest challenge facing insurance companies is how to balance profits and solvency. The industry is entering a period of higher regulatory action and reaction. But what standards will they have to meet and who will regulate them? Further, will complying with new surplus and investment standards jeopardize an insurer's ability to satisfy shareholders and meet its own financial goals? These questions will probably not be answered for many years. In the meantime, insurance companies will likely be taking a double books approach of testing for regulatory reporting on one side, while the other side is testing for investment strategies and new products. Blending the two together will not be easy. While insurers have improved their monitoring of cash flows and asset/liability matching, the danger of interest rate fluctuations is now a substantial risk. If rates edge upward, carriers risk disintermediation, or a major outflow of funds, if they are unable to keep pace with consumer demands for higher rates.

A concern shared by industry groups is that this condition, or additional casualty catastrophes (hurricanes, floods, earthquakes, terrorist activities) might strain carriers beyond their resources. And, even though their liquidity level may be higher, under risk based capital rules where future investment returns might be less, there will not be large "profit pools" to draw on for contingencies and as emergency claim funds. As a result, insurers may be forced to raise mortality and/or premium rates at a time when the forces of competition, regulatory pressures and consumer demand can least tolerate it.

Aside from slim profit margins, other factors which could influence future solvency include changing demographics which have reduced the demand for life insurance; increased competition for savings dollars / insurance products from the banking and mutual fund industry and the ever present threat of potential loss of insurance tax advantaged status. On the casualty side, the industry is still suffering from past baggage in the form of liability suits and environmental claims (asbestos, toxic, etc). And, of course, no one knows what mother nature is likely to dish out.

Convergence

Another concern for the industry is the ever-advancing insurance conglomerate. For a variety of reasons, there is still an "urge to converge" in the insurance industry that can effect the ultimate solvency of the company you choose for your clients. Why do insurers merge with banks, security dealers? Insurance companies buy or merge to expand their financial base, take advantage of cross-

selling opportunities and better serve customers. For many, the ability to gain access to a broader customer base is now crucial to their survival. A recent stimulus for the trend to re-appear is the passage of the Gramm-Leach-Bliley Act.

The new law enables financial service companies to establish holding companies that provide banking, brokerage and insurance services to their customers. There are several ways for this to happen:

- Insurers can acquire a bank or securities firms through a merger or acquisition.
- Insurers can establish partnerships and technology links with banks.
- Insurers can seek federal charters to offer their own banking products.

What could go wrong with a merged company? Nothing or a lot. However, it is well known that intragroup activities have become something of a concern within the US insurance industry, mainly because of the risk of exposure. This can occur even though off balance sheet transactions and guarantees have to be disclosed in an annual statement files with state insurance departments.

What can agents do about this? There is nothing you can do about a merger. However, since it is your duty to place business with reliable, safe companies, you should do everything possible to assess the solvency of insurance carriers prior to contracting for your client.

Safety Analysis Tools

As an insurance agent, it may unreasonable to expect you to analyze with high accuracy the true financial status of your carriers. Studies prove that in virtually all cases of failed companies, a direct correlation existed between the failure and financial strength ratings and / or certain benchmarks. Agents and regulators should have seen it coming and reacted sooner.

The regulators and rating companies who "missed the mark" simply backtracked. They re-invented their procedures and went on with their lives. Agents accused of the same mistake, however, might face a different scenario: loss of major clients and potential litigation. For some agents, this is a devastating prospect; for others, it is just another day.

If you are not concerned with the ethical reasons to practice solvency conduct for your client, consider that you have a legal obligation to "exercise reasonable care, skill and judgment in procuring insurance".

What is reasonable care? "If for some reason, the agent or broker knew, or should have known, that the insurer was insolvent at the time of placement, he or she may be liable for the loss". This language is only a step away from you being responsible for spotting troubled insurers.

Follow the preferred practice of assessing the solvency of potential carriers. Above all, if you discover or confirm something is wrong, the last thing you would want to do is continue promoting the company to clients. If it sounds like we are stating the obvious, take note: during the substantial failure rate of the 1980's, word on the street commonly fingered several prominent insurers as potential problem carriers. However, with higher commission structures and client bonus incentives, these companies had no problem attracting premium business in the hundreds of millions. Agents truly backed the failure and opened themselves and their clients to potential solvency exposures.

Ratings and Agents

Agents can easily be lulled into believing that placing business with an A-rated or better company is sufficient to stay out of trouble. Unfortunately, some in the industry are of the opinion that even well-rated companies are at risk of failing. If so, your clients and their attorneys may attempt to hold you responsible.

You might be asking what you are supposed to do: After all, if regulators and rating agencies with all their resources can't predict a solvency how can an independent agent or producer be expected to know? Isn't reliance on an authoritative third-party rating agency sufficient due diligence?

History has proven that a high rating is not a guarantee of anything other than the fact that at the time the ratings occurred, a particular company is more solid than another. And, this fact can change rapidly as it did in the late 1980's when even A+ company balance sheets deteriorated within a matter of months. The decline was not just a drop in ratings; for some companies it was a drop to liquidation. Also, rating agencies, as you will soon see, have created complicated systems of classification with many qualitative and quantitative measurements. This makes a complete explanation of their criteria almost impossible and it is why virtually all rating companies include disclaimers in their analysis.

In general, a higher rating can mean a lower probability of failure compared to insurers that are not rated as well. Again, however, there are no guarantees. You can advise your clients that the company is licensed in the state to conduct business and that the company and industry-accepted rating services suggest it is in good financial standing; however, you are not a guarantor of its future financial condition.

Here is how a sample disclosure might read: "While we are pleased to provide to you and explain the industry ratings of a particular company or alternate insurers, we do not make any independent investigation of a specific company's solvency or financial stability. We do not warrant or guarantee that any insurance company will remain solvent, and we will not be liable to any insurance applicant or insured for the failure or inability of an insurance company to pay claims."

Another misconception by agents is that the use of one rating service is sufficient to determine an insurer's financial condition. In fact, you would be encouraged to consult the ratings of at least three services. If the rating of your company by all three is consistent, there is some agreement among the raters on the financial condition of your company. However, if the ratings vary widely, this might be a signal that there are factors for concern.

Company Ratings

The activities of insurance company rating agencies have become increasingly prominent with the industry's financial difficulties and any well-publicized failures of several large insurers. The ratings issued by these agencies represent their opinions of the insurers' financial conditions and their ability to meet their obligations to policy holders. Rating downgrades are watched closely and can significantly affect an insurer's ability to attract and retain business. Even the rumor of a downgrade may precipitate a run on the bank, as in the case of Mutual Benefit years ago, and seriously exacerbate an insurer's financial problems.

There is little doubt that rating organizations play a significant role in the insurance marketplace. Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization; A.M. Best, a number of new raters emerged during the 1980s.

Questions have been raised about the motivations and methods of the raters in light of the sensitivity surrounding an insurer's financial conditions and what some perceive to be a rash of arbitrary downgrades. On the one hand, insurer ratings historically have been criticized for being inflated or overly positive. On the other side, there are concerns that raters, in an effort to regain credibility, have lowered their ratings arbitrarily in reaction to declines in the bond and real estate markets and the resulting insurer failures and diminished consumer confidence.

Of particular concern to some regulators and the industry are the practices of Weiss Research and Standard & Poor's (S&P) publications of qualified solvency ratings. Both the Weiss "safety" ratings and the S&P "qualified solvency" ratings are based on a strictly quantitative analysis of financial data. While there has been a concern about inflated ratings historically, Weiss has been criticized for marketing bad news to consumers, i.e. ratings that are skewed to the negative.

S&P's qualified solvency ratings also have been criticized for utilizing a scale that appears to be lower than their claims paying ability ratings. Some have accused S&P of using the qualified solvency ratings to "extort" insurers to pay a \$22,000 - \$28,000 fee to obtain a higher claims paying ability rating. S&P strongly denies these allegations and believes that consumers and agents properly understand the meaning of the qualified solvency ratings.

Both S&P and Weiss contend that their quantitative ratings provide valuable, unbiased information to consumers. The influence of the rating agencies and the practices of Weiss and S&P have prompted some regulators and insurers to suggest that the states and others should limit access to their database, which is utilized by these raters. There also have been calls for regulators and the NAIC to evaluate and certify rating agencies to ensure that their methods and practices meet certain established standards. However, other regulators have questioned whether it is appropriate and practical for regulators to withhold data or regulate rating agencies.

The regulators suggest that a more appropriate regulatory role is to improve consumers' understanding of the rating process and allow them to decide how to use the information raters provide. This discussion of the rating agencies presents certain factual information relating to the structure and activities of the five most prominent rating agencies: A.M. Best, Standard & Poor's, Moody's, Duff and Phelps and Weiss Research.

The philosophy, scope, fees, resources, process, methodology and classification scheme of each of these agencies is described below. While issues relating to certain practices of the raters are discussed, this is not an attempt to evaluate the validity of the raters' methods or practices.

Remember, an insurer failure may render you liable for losses or at least a target for expensive litigation. Therefore, it is reasonable that you should take steps to avoid this by becoming a student of insurance company ratings, regulations and benchmarks.

A.M. BEST COMPANY

The A.M. Best Company has been rating insurance companies since 1906 and its' long association with the industry is important to understanding its philosophy and approach. Its stated mission is "to perform a constructive and objective role in the insurance industry towards the prevention of insurer insolvencies". Best views its ratings as an inducement for insurers to operate in a prudent manner and maintain strong financial health. It actively consults with and advises companies on the basis for their rating and what actions a company must take to maintain its rating or improve it.

The objective of Best's rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company's relative financial strength and ability to meet its contractual obligations. Best conducts an extensive quantitative and qualitative evaluation of rated insurers based on various sources of information and knowledge of the company accumulated over a long period of time.

This knowledge is acquired through frequent contacts with company officials as well as statutory financial statements, special questionnaires and a variety of other sources. Typically, there will be meetings once a year with company management at Best's headquarters in Oldwick, New Jersey. There may be more meetings, if necessary, but Best attempts to meet at least once with a company over a two-year period, in addition to telephone contacts and correspondence.

If adverse developments occur that may affect a company's financial condition, Best will discuss the situation with management. If the company can present an effective plan to resolve the problem, Best may not immediately downgrade the company. The company's situation would continue to be monitored to ensure that the corrective action was implemented.

To obtain an alphabetical Best's rating, an insurer must have been in existence for at least five consecutive years of representative operating experience, have net premiums in excess of \$1.5 million for a life/health insurer, \$1.5 million in surplus for a property/casualty insurer, submit the requested financial information and pay a \$500 fee.

In a recent edition of Best Insurance Reports, 811 life/health insurers and 1,513 property/casualty insurers received an alphabetical rating. An additional 530 life/health insurers and 970 property/casualty insurers received rating "not assigned" (NA) classifications which explains why they did not meet Best's eligibility requirements. Of these non-rated companies, 291 life/health insurers and 597 property/casualty insurers received a Financial Performance Index (FPI) assignment, introduced in 1990.

Insurers are required to have at least three consecutive years of representative operating experience to obtain an FPI rating. The \$500 fee does not apply to companies receiving a "not assigned" rating classification or an FPI assignment. Insurers can elect to not have their rating published. If that happens, a company receives an NA-9 "Company Request" designation. In this instance, Best normally requires a minimum of two years to elapse before the company is again eligible for the assignment of a rating.

A typical Best's alphabetical rating consisted of nine categories, ranging from A+ (Superior) to O (Fair). In the 1990's, A.M. Best announced an expansion of its alphabetical categories to fifteen ratings. They range from A++ (Superior) to F (In Liquidation). The stated purpose of this expansion was to add finer distinctions among rated companies. About the same time frame, Best also

eliminated its "Contingent Rating" modifier and the rating categories of NA-7 (Below Minimum Standards) and NA-10 (Under State Supervision). Also, a new category NA-11 (Rating Suspended) was added.

Best's analysts typically possess significant experience with respect to financial analysis of insurance companies, acquired at Best as well as in the industry. The productivity of Best's analysts also is enhanced by sophisticated computer-based analytical tools and a large amount of information accumulated on each company. In addition, A.M. Best has ongoing consulting and educational arrangements with a professional reinsurer, an accounting firm and an actuarial firm to keep its analysis informed of current developments and industry issues.

Rating Methodology: The objective of Best's rating system, as described in its literature, is "to evaluate the factors affecting the overall performance of an insurance company in order to provide our opinion as to the company's relative financial strength and ability to meet contractual obligations."

Best's ratings are based on a quantitative evaluation of a company's performance with respect to profitability, leverage and liquidity and a qualitative evaluation of its spread of risk, reinsurance program, investments, reserves and management. The quantitative evaluation analyzes an insurer's reported financial condition and operating performance for at least the previous five years against industry peer group and Best's financial norms, utilizing more than 100 financial tests and supporting data.

If a company has a relationship with an affiliate through an investment, reinsurance or pooling agreement, data is consolidated to reflect this affiliation. Best views profit as a measure of the management's competence and ability to provide insurance at competitive prices and maintain a financially strong company. Best's profitability analysis reviews the degree, trends and components of earnings over the most recent five-year period. Net investment income, federal income taxes, expenses, mortality and persistency (life companies only), reinsurance, reserving practices and methods, statement versus market value of assets, regulatory constraints and underwriting experience are evaluated with regard to their relative effect on a company's earnings and capital and surplus. Also, the stability, trend, type and diversification of premium volume are evaluated as to their impact or potential impact on an insurer's reported statutory operating results.

Best is watchful of highly leveraged companies that are exposed to a high risk of instability and adverse changes in underwriting or economic conditions. Best reviews a number of leverage measures including the ratio of premium to capital and surplus, both gross and net of reinsurance. Affiliated investments are considered in the analysis of capital and surplus which also is adjusted to reflect the adequacy and equity of policy reserves, the market value of assets and potential default risk, market value fluctuation, nonperforming assets and reinsurance quality.

For property/casualty companies, Best looks at the ratio of reinsurance premiums ceded and loss reserves to surplus to measure the companies' exposure and dependence on reinsurance. The leverage analysis evaluates the relationship of net liabilities to adjusted surplus, insurance and investment risk based capitalization and other tests which measure a company's surplus or its asset and insurance risks. Best believes that insurers' liabilities should be supported by sound, diversified and liquid investments to meet unexpected needs for cash without the untimely sale of investments or fixed assets.

Best measures an insurer's quick liquidity position — the amount of cash and quickly convertible investments as a percentage of liabilities; "current liquidity" - the amount of cash and unaffiliated invested assets as a percentage of liabilities; and its cash flow position. The assessment of an insurer's liquidity incorporates an evaluation of the quality, market value, and diversification of assets, cash flow and asset/liability matching programs. Best also considers exposures maintained in single large investments. Stress tests assess the surplus impact of a 20 percent decline in common stock prices and the reduction in market value of bonds, preferred stocks and mortgage loans caused by a two percentage point increase in interest rates.

Best's qualitative evaluation looks at any items which cannot be totally reflected in the "numbers" that may have affected a company's performance or may potentially affect its long-term viability. The qualitative evaluation includes, but is not limited to the: 1) composition of a company's book of business, i.e. spread of risk; 2) adequacy of the reinsurance program; 3) quality, estimated market value and diversification of investments; 4) adequacy of reserves; 5) adequacy of surplus; 6) experience and competency of management; 7) asset/liability matching programs; and 8) the distribution and nature of liabilities structures. Also, Best recently instituted a "policy holder confidence factor" which measures a life insurer's relative vulnerability to all surrenderable liabilities in relation to its liquid assets.

To evaluate a company's spread of risk, Best analyzes its book of business on both a geographic basis and by line of business. Best also reviews a mix of a company's business relative to the distribution of its assets and their respective maturity and expected performance. Best looks for concentration in volatile lines of business or hazardous areas which can negatively affect an insurer's financial stability. Best reviews each insurer's reinsurance program to determine whether coverage is adequate for the potential risks involved.

If an insurer carries a large amount of reinsurance, Best evaluates the quality, diversification and purpose of the reinsurance. An insurer's rating may be adversely affected if it has a large amount of reinsurance or reinsurance recoverable, particularly if the financial condition of the reinsurer is unknown. Significant amounts of reinsurance undertaken primarily for financial reasons also may negatively affect an insurer's rating. Best examines an insurer's marketable assets (common stocks, bonds, mortgage loans) to determine the potential impact on its surplus if an insurer had to sell assets unexpectedly. The liquidity, diversification and quality of assets are evaluated to assess the uncertainty of the value to be obtained on their sale. The adequacy of an insurer's reserves is essential to Best's analysis of its profitability, leverage and liquidity.

For life companies, reserve analysis involves examining the types of business written and the valuation bases and interest assumptions used. For property/casualty companies, Best evaluates the losses and loss adjustment expenses on an ultimate payout basis. Best also considers the magnitude of a company's loss reserve discount relative to its surplus. In addition, the degree of uncertainty in loss reserve, recognizing that they are only actuarial estimates of future events, is evaluated. If the degree of uncertainty exceeds any equity in the reserves and is large in relation to net income and policy holder's surplus, Best's assessment of a company's reported profitability and leverage performance may be adjusted accordingly for rating purposes.

Best assesses the adequacy of an insurer's surplus relative to the degree of risk associated with its book of business. Best's rating evaluation accounts for the fact that varying degrees of underwriting risk and volatility exist with certain lines of business, with lines of higher volatility requiring greater

capital adequacy. Best prides itself on close working relationships and frequent contacts with the managements of the companies it reports on and rates.

Best's rating evaluation considers the character, objectives, experience and competence of an insurer's management. Various other important factors may be considered in the qualitative analysis, particularly those which may significantly affect a company's ability to meet its contractual obligations. Best's research and analysis in other areas may identify market or economic trends that could affect an insurer's financial condition. A company's relative standing within a rating category can be weakened, maintained or strengthened, based on the qualitative analysis. In a few instances, an insurer may be precluded from a particular rating classification or downgraded because of severe qualitative concerns.

Rating Classifications: Best has several different rating classification systems. The majority of companies rated receive an alphabetical rating which range from A+ (Superior) to C- (Fair). Double-plus rating categories of A++, B++ and C++ were previously added to the existing A+ rating (Superior), B+ rating (Very Good) and C+ (Fair) rating categories. In addition, rating categories of D (Below Minimum Standards), E (Under State Supervision) and F (In Liquidation) were added to complete a range that now extends from A++ through F.

Insurers that do not receive an alphabetical rating receive an NA classification for various reasons. The former rating categories NA-7 (Below Minimum Standards) and NA-10 (Under State Supervision) were eliminated in 1992. Companies previously rated in these categories were included in the expanded alphabetical ratings. Also, a new category NA-11 (Rating Suspended) was added. A portion of the not assigned companies also received an FPI rating. Best issues reports even for non-rated companies. Best's rating classifications are described below in abbreviated form.

A++ and A+ (Superior): Assigned to those companies which in Best's opinion have achieved superior overall performance when compared to Best's standards. According to Best, A++ and A+ (Superior) rated insurers have a very strong ability to meet their policy holders and other contractual obligations over a long period of time.

A and A - (Excellent): Assigned to those companies which, in Best's opinion, have achieved excellent overall performance when compared to Best's standards. According to Best, A and A* (Excellent) rated insurers have a strong ability to meet their policy holder and other contractual obligations over a long period of time.

B++ and B+ (Very Good): Assigned to those companies which in Best's opinion have achieved very good overall performance when compared to Best's standards. According to Best, B++ and B+ (Very Good) rated insurers have a strong ability to meet their policy holder and other contractual obligations, but their financial strength may be susceptible to unfavorable changes in underwriting or economic conditions.

B and B- (Good): Assigned to those companies which in Best's opinion have achieved good overall performance when compared to Best's standards. According to Best, B and B- (Good) rated insurers generally have an adequate ability to meet their policy holder and other contractual obligations, but their financial strength is susceptible to unfavorable changes in underwriting or economic conditions.

C++ and C+ (Fair): Assigned to those companies which, in Best's opinion, have achieved fair overall performance when compared to Best's standards. According to Best, C++ and C+ (Fair) rated insurers generally have a reasonable ability to meet their policy holder and other contractual obligations, but their financial strength is vulnerable to unfavorable changes in underwriting or economic conditions.

C and C- (Marginal): Assigned to those companies which, in Best's opinion, have achieved marginal overall performance when compared to Best's standards. According to Best, C and C- (Fair) rated insurers have a current ability to meet their policy holder and other contractual obligations, but their financial strength is very vulnerable to unfavorable changes in underwriting or economic conditions.

D (Below Minimum Standards): Assigned to companies which meet Best's minimum size and experience requirements, but do not meet Best's minimum standards for G rating. Note: This rating category was formerly the NA-7 (Below Minimum Standards) Rating Not Assigned classification.

E (Under State Supervision): Assigned to companies which are placed under any form of supervision, control or restraint by a state insurance regulatory authority such as conservatorship or rehabilitation, but does not include liquidation. May be assigned to a company under a cease and desist order issued by a regulator from a state other than its state of domicile. Note: This rating category was formerly the NA-10 (Under State Supervision) Rating Not Assigned classification.

F (In Liquidation): Assigned to companies which have been placed under an order of liquidation or have voluntarily agreed to liquidate. Note: This was a new rating category in 1992 to distinguish between companies under state regulatory supervision and those in the process of liquidation.

Performance Modifiers: Best assigns modifiers to their alphabetical ratings to identify a company whose assigned rating has been modified because of performance, affiliation or contractual obligations. The full list of modifiers are listed below:

"w" Watch List: Indicates the company was placed on Best's Rating "Watch List" during the year to advise its subscribers that the company is under close surveillance because it has experience a downward trend in its current financial performance or may be exposed to a possible legal, financial or market situation which could adversely affect its performance.

"x" Revised Rating: Indicates the rating shown was revised during the year.

Affiliation Modifiers:

"e" Parent Rating: Indicates that the rating assigned is that of the parent of a domestic subsidiary in which ownership exceeds 50 percent. The rating is based on the consolidated performance of the parent own performance after attaining five consecutive years of representative experience; have common management with its parent; underwrite similar lines of business; and have interim leverage and liquidity performance comparable to that of its parent.

"g" Group Rating (property/casualty companies only): Indicates the rating is assigned to an affiliated group of property/casualty companies. To qualify for a group rating, the companies in a group must be affiliated via common management and/or ownership; pool a substantial portion of their net business; and have only minor differences in their underwriting and operating performance. All members are assigned the same rating and financial size category, based on the consolidated performance of the group.

"p" Pooled Rating: Indicates the rating assigned to companies under common management or ownership that pool 100 percent of their net business. All premiums, expenses and losses are prorated in accordance with specified percentages that reasonably relate to the distribution of the policy holders' surplus of each group member. All members participating in the pooling arrangement are assigned the same rating and financial size category, based on the consolidated performance of the group.

"r" Reinsured Rating: Indicates the rating and financial size category assigned to the company are those of an affiliated carrier that reinsures 100 percent of the company's net premiums written.

"s" Consolidated Rating (property/casualty companies only): Indicates the rating is assigned to a parent company and is based on the consolidated performance of the company and its domestic property/casualty subsidiaries in which ownership exceeds 50 percent. The rating applies only to the parent company because subsidiaries are normally rated on the basis of their own financial condition and performance. A.M. Best does not assign an alphabetical rating to a number of insurers because they do not meet certain requirements such as size or operating experience. A list of these not assigned classifications is provided below with brief explanations.

NA-1 Special Data Filing: Assigned primarily to small mutual and stock companies that are exempt from the requirement to file the standard NAIC annual statement. These company reports are based on selected financial information requested by Best, and the majority are submitted via Best's Data Collector under a cooperative program with the National Association of Mutual Insurance Companies (NAMIC) and other supporting organizations.

NA-2 Less than Minimum Size: Assigned to companies that file the standard NAIC annual statement, but do not meet Best's minimum size requirement of writings of \$1.5 million for life/health insurers or \$1.5 million of surplus for property/casualty insurers.

NA-3 Insufficient Operating Experience: Assigned to a company which meets, or is anticipated to meet, Best's minimum size requirement, but has not accumulated at least five consecutive years of representative operating experience.

NA-4 Rating Procedure Inapplicable : Assigned to a company when the nature of its business and/or operations is such that the normal rating procedure for insurers does not properly apply. Examples are companies writing lines of business uncommon to the life/health or property/casualty field; companies not soliciting business in the United States; companies retaining only a small portion of their gross premium writings; companies which have discontinued writing new and renewal business and have a defined plan to run-off existing contractual obligations; or companies whose sole operation is accepting business written directly by a parent, subsidiary or affiliated insurance company.

NA-5 Significant Change: Assigned to a previously rated company which experienced a significant change in ownership, management or book of business whereby its operating experience may be interrupted or subject to change; or any other relevant event which has or may affect the general trend of a company's operations.

NA-6 Reinsured by Unrated Reinsurer: Assigned to a company which has a substantial portion of its book of business reinsured by unrated reinsurers and/or has reinsurance recoverables from unrated reinsurers which represent a substantial portion of its policy holders' surplus. Exceptions are unrated foreign reinsurers that comply with Best's reporting requirements.

NA-7 Below Minimum Standards: Discontinued in 1992 and replaced by D rating.

NA-8 Incomplete Financial Information: Assigned to a company that is eligible for a rating, but fails to submit complete financial information for the current five-year period under review. This requirement includes all domestic subsidiaries in which the company's ownership exceeds 50 percent.

NA-9 Company Request: Assigned to a company that is eligible for a rating, but requests that the rating not be published. The majority of these companies, such as captives, operate in markets that do not require a rating, but cooperate with Best's request for financial information so that a report can be prepared and published on their company. The classification is also assigned to a company that requests its rating not be published because it disagrees with Best's rating assignment or payment of the \$500 rating fee. In this situation, Best's policy normally requires a minimum of two years to elapse before the company is again eligible for the assignment of a rating.

NA-10 Under State Supervision : Discontinued in 1992 and replaced by rating of either E or F.

NA-11 Rating Suspended: Assigned to a previously rated company which has experienced a sudden and significant event affecting the company's financial position and operating performance, of which the impact cannot be evaluated due to a lack of timely or appropriate information. A recent sample distribution of insurers by Best ratings found that of the total companies rated, 41.7 percent of life/health insurers and 52.6 percent of property/casualty insurers were assigned a "Superior" or "Excellent" rating. Of the companies receiving alphabetical or NA-7 (Below Minimum Standards) ratings, 68.8 percent of life/health and 82.9 percent of property/casualty insurers were assigned a "Superior" or "Excellent" rating.

Financial Performance Index (FPI): In the 1990's, A.M. Best instituted the FPI rating for companies not meeting the size and operating experience requirements for an alphabetical rating. The FPI is assigned to companies that have three years of representative operating experience, submit NAIC statements, complete a supplemental rating questionnaire and qualify for NA-2 or NA-3 categories. The assignment of the FPI involves the same notification and discussion process with company management as with alphabetically rated companies.

The FPI procedure includes both a quantitative and qualitative review of a company's operating and financial performance. The quantitative evaluation is based on an analysis of a company's financial performance, utilizing essentially the same key tests required for the alphabetical rating. The qualitative review for the FPI rating is not as extensive as that for an alphabetical rating, but it does include adjustments for adequacy of reinsurance protection, geographic spread of risk and loss exposure by product line.

A company is assigned an index of from 1 to 9 based on the quantitative and qualitative review of its overall performance. An FPI of 1 is assigned to a company that does not have three consecutive years of representative operating experience or, in a few cases, was assigned an FPI which was lower than it found acceptable and requested that it not be published.

Dissemination of Rating Information: Best disseminates company reports and ratings through various publications and information services. Best's Insurance Report are published annually and available to consumers through most public libraries and state insurance departments which receive complimentary copies.

Updated year-end ratings and interim rating changes are also made available through various subscription publications, weekly, monthly and quarterly; daily through Best Link, the on-line computer network service; and through Best Line, a direct dial 900 rating service. These publications and services are complimented by other Best reports and analyses that deal with industry issues and developments.

STANDARD & POOR'S

Standard and Poor's (S&P) has emerged as the second leading insurer rating agency in terms of the number of domestic insurers rated, with virtually the same number of insurers assigned letter grade ratings as A.M. Best. It has been rating bonds since 1923 and insurance companies' claims paying ability since 1983. S&P's insurer rating activity draws from its experience and procedures in rating debt issues and utilizes a similar classification framework, but is conducted by professional analysts whose background, experience and/or training is focused on the insurance industry.

S&P's philosophy and approach to rating the financial strength of insurers is more like that of Moody's and Fitch Ratings than like A.M. Best. S&P sees its role as one of providing risk assessment of insurers to insurance buyers rather than serving as an advisor to insurers to assist them in improving their financial condition and rating. S&P's Insurance Rating Services is one of six departments within its Ratings Group, which has a staff in excess of 700 located in offices in seven countries.

S&P's Insurance Rating Services provides ratings on fixed income securities, including long-term debt, commercial paper and preferred stock issued by insurance companies, as well as claims paying ability ratings and qualified solvency ratings of the financial strength of insurers. S&P's claims paying ability rating is an assessment of an operating insurance company's financial capacity to meet its policyholder obligations in accordance with their terms.

Claims paying ability ratings are based on a comprehensive quantitative and qualitative financial analysis using various sources of information, including interviews with company management. S&P introduced qualified solvency ratings in 1991, after two years of development, to extend its coverage of opinions on insurers in response to market demands for information on insurers for which it did not provide a claims paying ability rating. The qualified solvency ratings are based on a statistical analysis of statutory financial data filed with the NAIC and purchased by S&P.

S&P's qualified solvency methodology provides a solely statistically based indication of financial strength among insurers and differentiates broadly between classes of risk to policy holders. S&P's insurer ratings are not recommendations to buy, retain or surrender a policy from any particular insurer. Some regulators and insurers have questioned the fairness of qualified solvency ratings.

Conversely, other insurers have referred to their qualified solvency rating, along with other agencies ratings, in sales material or have expressed disappointment in not receiving a qualified solvency rating. Some brokers and agents have expressed the view that qualified solvency ratings are not well understood in the market. S&P notes others have expressed the view that qualified solvency ratings add useful information to the market.

All claims paying ability ratings are voluntary and insurers pay a rating fee that typically ranges from \$15,000 to \$32,000 depending on size, number of affiliated insurers, and other factors. In connection with their initial application for a claims paying ability rating, insurers have the option of not completing the process and/or not having a claims paying ability rating published.

Once a claims paying ability rating is published, the insurer can request that it be withdrawn, although this option has been very rarely exercised. A statement of S&P's current opinion of the insurer's financial strength will be released at the time of the rating withdrawal, if an insurer requests that its claims paying ability rating be withdrawn because it anticipates that the rating will be lowered, S&P will complete its review process and if a rating downgrade is viewed as warranted, will announce it before withdrawing the rating.

Rating Process: S&P's claims paying ability rating process begins with an application and a commitment from an insurer to provide the necessary financial information for a full evaluation. A lead analyst is assigned to work with the company and obtain financial information including five years of statutory financial statements, GAAP financial statements (if available) information provided on special questionnaires dealing with debt securities, mortgage loans and real estate investments. Various spreadsheets, profiles and financial ratios are prepared to assist S&P analysts in forming an initial opinion about the financial condition of an insurer relative to Best's standards.

S&P analysts also meet with company management to discuss issues relating to the company's business goals and strategies, profitability, underwriting standards, reserving policy, leverage and use of debt, earnings outlook, accounting policies, targeted markets, acquisition and growth philosophy, planning processes, asset distribution and quality, and asset/liability management. In an initial rating, S&P prefers to meet with an insurer for a full day at its headquarters to have full access to the appropriate personnel. Subsequent meetings may be held at the company's location or at S&P.

Subsequent to the management interview, the lead analyst prepares a report and preliminary rating based on a quantitative and qualitative evaluation of all the information compiled. The report is presented to a rating committee comprised of five or more senior insurance industry specialists and also including, when necessary, other S&P specialists in areas such as real estate, private placements and other investments. The rating committee scrutinizes the preliminary rating, questions the analyst's assumptions, verifies the material facts and challenges the analyst's conclusions. After this review, the rating committee makes a final determination on the rating that will be assigned to the insurer.

The insurer is informed of the committee's rating assignment and the basis for the rating. However, the nature of the rating committee's deliberations and the identity of its members are not disclosed to the insurer. If the company can provide additional information and/or demonstrate that the basis for the initial rating was incorrect, the committee may revise its rating decision. Otherwise, the rating stands.

An insurer does have the option of requesting that an initial claims paying ability rating not be published. S&P believes that this option is necessary to ensure that it receives the cooperation of insurers to provide the information that it needs to do a proper evaluation, not only with respect to the initial rating assignment, but in connection with S&P's ongoing rating surveillance as well. S&P indicates, however, that this is an option that has rarely been exercised, and that when exercised, has to date virtually always resulted in ratings in the AA, A or BBB categories not being published. Also, insurers that decline their claims paying ability rating will receive a qualified solvency rating.

Once assigned and approved, insurers' ratings are released through monthly and quarterly publications as well as made available to consumers over the telephone. After a claims paying ability rating is assigned, S&P analysts continue to monitor an insurer's performance for new developments. The surveillance process involves reviewing the insurer's financial statements and reports each year, annual meetings with company management, and monitoring company, industry and market developments.

Any rating may be reviewed at any time when new information suggests that the financial strength of the insurer may have changed. S&P will always notify a company when a rating change is contemplated, and will meet with the company as part of the process leading up to the potential change. S&P also may issue a general advisory, referred to as a:

"CreditWatch", if new developments may affect an insurer's claims paying ability rating. Insurers are always made aware of a rating change or a CreditWatch advisory prior to its release.

Rating Methodology: S&P conducts a comprehensive quantitative and qualitative evaluation in assessing an insurer's financial strength and ability to meet its future obligations to policy holders for the claims paying ability rating. S&P applies a common set of qualitative principles to every company regardless of its line of business, but then tailors its analytical approach to each of the four primary insurance industry segments: life/health insurers; property/casualty insurers; consolidated property/casualty groups; and professional reinsurers. Its rating methodology profile covers eight basic areas 1) industry risk; 2) management and corporate strategy; 3) business review; 4) operational analysis; 5) investments; 6) capitalization; 7) liquidity; 8) financial flexibility.

S&P also looks at interest rate management and asset/liability matching for life insurers and loss reserve adequacy for property/casualty insurers. Insurers are "benchmarked" against industry norms in the quantitative portion of the evaluation, but there is no specific formula or algorithm used to score companies based on their statistical results.

S&P's industry risk analysis looks at four competitive factors; 1) potential threat of new entrants; 2) threat of substitute products or services; 3) rivalry among existing firms; 4) bargaining power of buyers/suppliers. Industry sectors are defined largely by the type of insurance written. When a company does business in more than one sector, a weighted average risk score is assigned based on premium revenue. With respect to management and corporate strategy, S&P evaluates whether the strategy management has chosen is both consistent with the organization's capabilities and whether it makes sense in its marketplace.

S&P also evaluates a company's operational skills, which essentially involves an assessment of a company's ability to execute its chosen strategy. S&P evaluates management's expertise in operating each of the company's lines of business as well as the adequacy of audit and control systems; its financial risk tolerance, which relates to the amount of debt in its capital structure and the level of

operating leverage which a company is willing to accept; its organizational structure, and how it fits the company's strategy.

S&P's business review analysis identifies the company's fundamental characteristics and its source of competitive advantage or disadvantage. This includes a description of the portfolio of business units and/or product lines, distribution systems, and the degree of business diversification. The business review includes analysis of those aspects of the business that affect the absolute level, growth rate and quality of the revenue base and focuses on the long-term revenue generating capabilities of the insurer.

Through an analysis of operating results, S&P determines a company's ability to capitalize on its strategy and company strengths. Operating results are analyzed independently of the firm's operating leverage. S&P's analysis of an insurer's earnings performance focuses on its underlying economic profitability rather than its stated statutory net gain. If available, S&P will review a firm's GAAP financials in making its assessment, although it will rely on statutory figures if GAAP financials are unavailable.

S&P focuses on the after-tax return on assets as the most comprehensive ratio not affected by leverage. For a life/health insurer, S&P's analysis includes a review of its persistency, expense structure, mortality/morbidity experience, effective tax ratio, pricing policies and actual performance versus pricing. For a property/casualty company, S&P examines underwriting performance including premium growth rates, loss ratios, expense ratios, combined ratio and loss reserve adequacy. The trend and stability of a company's earnings are also evaluated.

S&P's analysis of an insurer's investments considers the insurer's allocation of assets among investments such as bonds, mortgages, preferred stock, real estate, common stock and other invested assets. The assets are evaluated for credit quality and diversification. An insurer's asset allocation is also examined to determine how appropriate it is to support policyholder liabilities. Asset quality is reviewed throughout the investment portfolio, and charges are applied against the insurer's capital for problem and risky assets to establish what S&P believes to be the appropriate level of investment reserves. Delinquencies on mortgage portfolios, restructured mortgage loans, loans in the process of foreclosure and foreclosed real estate are also assessed.

S&P applies a default rate model, based on historical experience and current S&P projections, to determine the appropriate level of investment reserve needed for mortgages, bonds and other fixed income assets. Credit is given for existing investment reserves in the statutory balance sheet. Equity assets, including common stock, real estate, and schedule BA assets, are reviewed for appropriateness of valuation. S&P may adjust capital to reflect what it believes to be overvalued assets or to incorporate hidden asset values.

S&P also evaluates how well an insurer manages its interest rate risk and asset/liability matching strategies relative to its product lines. S&P reviews an insurer's asset/liability management by identifying the specific asset and liability durations and cash flows of interest rate sensitive portfolios. Investment risk and the degree of mismatch between the maturity and duration of the investment portfolio with an insurer's liability structure is principal to S&P's evaluation of management's tolerance for risk.

S&P's analysis of insurers' capitalization incorporates financial leverage and fixed charge coverage concepts as well as the degree of operating leverage. The ratios used by S&P for all insurers are total

debt to capital; long-term debt to capital; short-term debt to capital; fixed charge coverage; preferred stock to capital; and fixed charge coverage of preferred dividends. The analysis of operating leverage is analyzed in relation to the business lines of an insurer. For life/health insurers, operating leverage is defined as total liabilities to statutory capital, treating the mandatory securities valuation reserve (MSVR) as capital and excluding separate accounts from liabilities. For property/casualty insurers, the applicable ratios are net written premiums to surplus; loss reserves to surplus; loss reserves to earned premiums; ceded written premium to gross written premium; and investments in subsidiaries/affiliates to surplus. Other risks inherent in an insurer's operations such as asset/liability mismatch are also examined in relation to the level of capital. In addition, the use and quality of reinsurance is analyzed.

Finally, the quality of capital is analyzed in terms of the degree of exposure to reinsurers and equity assets such as common stocks, including investment in affiliates, real estate equities, and equity investments in partnerships relative to the capital base of the firm.

Property/casualty insurers' loss reserves are also evaluated for adequacy. S&P's loss reserve analysis looks at six lines individually and combined utilizing data filed on Schedule P: personal auto liability; commercial auto liability; other liability; medical malpractice; workers' compensation; and commercial multi-peril.

S&P utilizes several different standard techniques to arrive at a degree of confidence in the loss reserve for each line and to identify areas where management will be asked to explain deviations from expected results. In evaluating liquidity for life insurers, S&P focuses on an insurer's ability to handle reasonable increases in cash outflows due to lapses, surrenders, policy holder loans or other cash withdrawals. S&P analyzes the nature of a company's policy holder liabilities and their associated surrender charges and/or market valuation charges in determining the susceptibility to increased cash outflows before policy maturity. In addition, it looks at the maturity structure of large dollar investment-oriented contracts such as guaranteed investment contracts (GICs) in evaluating a company's liquidity needs.

The amount of liquid assets available to meet increased cash outflows and policy maturity are compared. S&P defines liquid assets to include cash and short-term securities; government and government-backed securities; investment grade public bonds; private placements in NAIC categories 1 or 2 maturing in one year or less; and other liquid assets as determined by S&P through discussions with management.

The liquidity ratios examined by S&P for life/health insurers include operating cash flow to benefits paid; operating cash flow to liabilities; and cash and short-term investments to invested assets. For property/casualty insurers, S&P looks at underwriting cash flow to sources/uses; total cash flow to sources/uses; and cash and short-term investments to invested assets.

Finally, S&P evaluates an insurer's financial flexibility in terms of its capital requirements and capital sources. Capital requirements refer to factors that may give rise to an exceptionally large need for either long-term capital or short-term liquidity. Capital sources involve an assessment of the extent to which a company has access to short and long-term capital beyond normal operating earnings and cash flow.

Rating Classifications And Distribution Claims-Paying Ability Ratings: As indicated above, S&P provides either of two types of ratings of an insurer's financial strength: a claim paying ability rating or

a qualified solvency rating. The claims paying ability rating is an opinion of an insurer's financial capacity to meet the obligations of its insurance policies in accordance with their terms.

Claims paying ability ratings are further divided into two classifications: secure and vulnerable. Rating categories from "AAA" to "BBB" are classified as "secure" claims paying ability ratings and are used to indicate insurers whose financial capacity to meet policy holder obligations is viewed on balance as sound. Rating categories from "BB" to "D" are classified as "vulnerable" claims paying ability ratings and are used to indicate insurers whose financial capacity to meet policy holder obligations is viewed as vulnerable to adverse developments. In fact, the financial capacity of insurers rated "CC" to "C" may already be impaired, while insurers rated "D" are in liquidation. Ratings from "AA" to "CCC" may be modified by a plus or minus sign to show the relative standing of the insurer within those rating categories. The specific claims paying ability ratings are further described below:

AAA: Insurers rated AAA offer superior financial security on both an absolute and relative basis. They possess the highest safety and have an overwhelming capacity to meet policy holder obligations.

AA: Insurers rated AA offer excellent financial security, and their capacity to meet policy holder obligations differs only in a small degree from insurers rated AAA.

A: Insurers rated A offer good financial security, but their capacity to meet policy holder obligations is somewhat more susceptible to adverse changes in economic or underwriting conditions than more highly rated insurers.

BBB: Insurers rated BBB offer adequate financial security, but their capacity to meet policy holder obligations is considered more vulnerable to adverse economic or underwriting conditions than that of more highly rated insurers.

BB: Insurers rated BB offer financial security that may be adequate but caution is indicated since their capacity to meet policy holder obligations is considered vulnerable to adverse economic or underwriting conditions and may not be adequate for "long-tail" or long-term policies.

B: Insurers rated B are currently able to meet policy holder obligations, but their vulnerability to adverse economic or underwriting conditions is considered high.

CCC: Insurers rated CCC are vulnerable to adverse economic or underwriting conditions to the extent that their continued capacity to meet policy holder obligations is highly questionable unless a favorable environment prevails.

CC and C: Insurers rated CC and C may not be meeting all policy holder obligations and may be operating under the jurisdiction of insurance regulators and are vulnerable to liquidation.

D: Insurers rated D have been placed under an order of liquidation.

Qualified Solvency Ratings: S&P's qualified solvency ratings are based strictly on the application of statistical analysis to statutory financial data filed by insurers with the NAIC. The objective of the statistical analysis is to distinguish insurers that are financially weak or more likely to get into financial trouble from insurers that are financially strong or less likely to encounter financial difficulty.

Multi-variant discriminant analysis is used to develop a model which assigns a numerical score (Z-score) to each insurer based on its financial results. The financial ratios or variables which comprise the model are measured over a four-year period to incorporate trend. The model is tested using alternate data sets to affirm its stability and ability to predict failed insurers.

The analysis is conducted separately for the four different industry segments: consolidated property/casualty insurers; individual property/casualty insurers; professional reinsurers; and life/health insurers. The procedures used were reviewed by independent actuarial and accounting consultants. The models used are updated as new data become available and the characteristics of failed and solvent insurers change over time.

Insurers' Z-scores are divided into three broad groups. Insurers with the highest scores are assigned a BBBq rating indicating "adequate" financial security. Their scores most closely resemble those of financially strong insurers. The next segment of scores is assigned a BBq rating, indicating that financial security "may be adequate". Insurers receiving the lowest scores are rated Bq, indicating a "vulnerable" financial condition. Their scores most closely resemble those of insurers that have actually experienced financial difficulty.

Insurers that do not voluntarily apply for a claims paying ability rating are assigned a qualified solvency rating based on a quantitative analysis of their statutory financial data. Qualified solvency ratings are computed for individual insurers on a stand-alone basis, without consideration for strength or weakness that might be added by a parent or affiliated companies. Qualified solvency rating designations range from BBBq to Bq. The "q" suffix indicates the qualified nature of the rating because it is based strictly on a statistical analysis. The definitions of the qualified solvency ratings are given below:

BBBq: Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing adequate or better financial security.

BBq: Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing financial security that may be adequate.

Bq: Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing vulnerable financial security. S&P has been criticized by some insurers and regulators because the highest qualified solvency rating possible is BBBq which appears to be lower than the highest claims paying ability rating possible, AAA. However, S&P's rationale for the use of B-range symbols for qualified solvency ratings is that they are consistent with the definitions of S&P's claims paying ability ratings.

In S&P's Insurer Solvency Review, it points out that a BBB claims paying ability is considered secure, but not superior. Similarly, a BBBq rating is presumed to represent a secure insurer, although it is uncertain how secure based on its statistical analysis alone. S&P acknowledges, "It is possible that a more comprehensive evaluation would reveal that a BBBq-rated insurer could be rated BB or lower on the claims paying ability rating scale. It is most likely, however, that an insurer rated BBBq would be rated among the top four categories (AAA to BBB) for claims paying ability."

S&P describes insurers rated BB for claims paying ability as providing "financial security that may be adequate but caution is indicated since their capacity to meet policy holder obligations is considered

vulnerable to adverse economic or underwriting conditions..." S&P links that definition to its BBq qualified rating, indicating that insurers rated BBq appear weaker than insurers rated BBBq but, nonetheless, offer financial security that may be adequate.

The most likely range of claims paying ability rating is A to B. S&P's definition of a B claims paying ability rating says: "Vulnerability to adverse economic or underwriting conditions is considered high." A Bq rating is intended to convey a similar notion. Insurers rated Bq show material weaknesses according to the financial data, similar to insurers that have encountered financial difficulty in the past. However, just as some insurers rated BBBq in reality may be weaker than the data suggest, it is probable that some insurers rated Bq may in fact be stronger than the data suggest.

Nevertheless, insurers with qualified solvency ratings of Bq would, on their own merits, be least likely to receive claims paying ability ratings in the "secure" range of BBB or higher. S&P contends that consumers properly understand the distinction between the claims paying ability and qualified solvency ratings. However, some insurers and regulators believe that consumers tend to equate the two.

No research has been conducted to determine whether consumers properly understand the difference between the two types of ratings. S&P bases its conclusions on telephone contacts with consumers. Because of concerns about consumer misperceptions, some insurers and industry trade associations indicate that they feel coerced to "purchase" a claims paying ability rating the fee for which typically ranges from \$22,000-\$28,000 and which may be different than their qualified solvency rating. Some insurers have claimed that it is unfair to subject them involuntarily to a statistically based rating and to be confined to a qualified B-range rating because they have not paid for a more in-depth claims paying ability rating. Some smaller insurers express additional concerns that S&P's qualified solvency rating model tends to favor larger insurers.

However, S&P believes that the qualified solvency methodology provides an unbiased indication of insurers' financial strength and can differentiate broadly between classes of risk to policy holders. It further maintains that the classification framework used for the qualified solvency rating is appropriately conservative to protect consumers. In a recent sample distribution of claims paying ability and qualified solvency ratings, of the total companies rated, 16 percent of life/health and 19 percent of property/casualty companies received an AAA (Superior) or AA (Excellent) rating. Of the companies receiving claims paying ability ratings, 78.1 percent of life/health and 75.6 percent of property/casualty insurers received an AAA or AA rating.

Dissemination of Rating Information: S&P disseminates its ratings and other financial information about insurers through several publications. S&P's Insurance Book is a quarterly looseleaf service providing comprehensive coverage of more than 500 insurance companies: property/casualty, life/health, reinsurance, bond insurance and mortgage insurance. S&P's Insurance Digests are quarterly publications containing capsule reports on S&P-rated companies. S&P's Insurers Ratings List is a monthly publication listing all of S&P's insurer claims paying ability ratings by industry. Select Reports are four-page reports, excerpted from S&P's Insurance Book, containing a full, in-depth review of each company. Consumers also can obtain information on up to five insurers at a time, free of charge, by calling S&P's Rating Information Department.

MOODY'S INVESTOR SERVICE

Moody's Investors Service was founded in 1900 by John Moody, who invented bond ratings in 1909. Today, Moody's rates securities of some 4,000 industrial companies, public utilities, banks and other financial institutions. In addition to bonds, Moody's rates the credit worthiness of a wide variety of financial obligations, such as commercial paper, bank deposits, money market funds and GICs.

In the insurance sector, Moody's has been rating the debt securities of insurance companies since the mid-1970s. Moody's began assigning insurance company financial strength ratings in 1986. Although Moody's rates fewer insurers than A.M. Best or S&P, it has acquired a solid reputation for thoroughness and expertise in its insurer rating activities.

Moody's financial strength ratings reflect its opinion as to an insurer's ability to discharge senior policy holder obligations and claims. It seeks to measure "credit risk", i.e., the risk that an insurer will fail to honor its senior policy holder claims in full and on a timely basis. Moody's financial strength ratings are based on quantitative and qualitative analysis of the industry, regulatory trends and the business fundamentals of the insurer.

Insurers can apply to Moody's for a financial strength rating. There is a basic annual appraisal fee of \$25,000 for life insurance financial strength ratings and \$22,000 for property/casualty financial strength ratings. In addition, where Moody's believes there is sufficient policy holder and investor interest, Moody's is prepared to assign financial strength ratings to life companies that have not requested a rating.

Although Moody's will generally solicit the company's cooperation under such circumstances, Moody's is prepared to go forward without company participation in the basis of publicly available information. Moody's will only do so if adequate information is available in the public domain to reach a credible rating conclusion. Moody's does not charge a fee, at least initially, to insurers that have not applied for a rating.

Moody's primary focus on the life side has been insurers that are large annuity writers, but it is expanding into other segments of the life industry and also has rated property/casualty insurers. Moody's financial strength ratings and debt ratings for insurers are produced by its Insurance Group, which is part of its Financial Institutions Group. Moody's committee rating process also utilizes expertise of other Moody's staff and management in analyzing and rating insurers.

Rating Process: In assigning financial strength ratings to insurers, Moody's employs a committee process that draws upon the perspective and expertise of a number of analysts, associate directors and directors. The lead analyst is responsible for analyzing the insurer and preparing a rating recommendation to Moody's Corporate Rating Committee. This committee is ultimately responsible for the final rating decision.

Once a committee decision is reached, the insurer is informed of the decision, and the rating is usually released to the public shortly thereafter. Once a rating has been assigned, it is considered to be "continuously under review", and it can be changed if Moody's becomes aware of developments within the company, the industry, or any other general developments that Moody's believes could change the fundamental risk embodied in the rating. Moody's analysis typically, but not always, involves meeting with the company management.

Insurers are given the right to appeal first-time financial strength ratings and to meet with Moody's staff to disclose new information that may be relevant to the rating decision. However, since 1992, Moody's has reserved the right to disclose an insurer's rating, whether the insurer agrees with its rating or not. When entering new areas, Moody's has initially given insurers the option of not having their rating published until a "framework of comparability is achieved within the given sector"¹. Recently, Moody's determined that its rating coverage of U.S. life insurers has met this standard and, therefore, it no longer offers the refusal option to life insurers. It does still offer the refusal option to property/casualty insurers.

Rating Methodology: Moody's financial strength ratings are based on industry analysis, regulatory trends, and an evaluation of an insurer's business fundamentals. Its industry analysis examines the structure of competition within the insurer's operating environment and its competitive position within that structure. The analysis of regulatory trends attempts to develop an understanding of potential changes in a particular country's regulatory system and tax structure. The analysis of a company's business fundamentals focuses primarily on financial factors, "franchise value", management and organizational structure/ownership.

In conducting its industry analysis, Moody's look at a number of factors including: the degree of concentration within the industry; the extent of inter-industry competition; the degree to which competition is likely to remain orderly; and the level of national protectionism, explicit or implicit. Moody's analysis of regulatory trends includes consideration of potential changes in regulations or taxation that could inhibit an insurer's competitive position or could lead to a significant restructuring of segments of the industry. Moody's also considers the failure-resolution practices of state regulators in its overall financial strength rating.

Moody's analysis of the financial fundamentals of a company encompasses capital adequacy, investment risk, profitability and liquidity. To assess capital adequacy, Moody's adjusts an insurer's statutory data to estimate its economic capital as a going concern. Adjustments include consideration of the conservatism in statutory reserves and asset valuation, acquisition costs recoverable from future earnings, hypothecation of future earnings through financial reinsurance, and investments in subsidiary companies. Moody's also employs a risk-based benchmark capital ratio to assess capital adequacy which recognizes an insurer's mix of lines of business and assets, each of which has varying risk characteristics, including asset default, pricing adequacy, and interest rate risk. Moody's assesses a number of factors to reach conclusions about an insurer's expected long-run profitability and the risk that actual results may differ from expected profits. The factors assessed include 1) market focus of the insurer; 2) competitive dynamics in each market segment; 3) relative distribution costs; 4) underwriting record and outlook; 5) investment strategy.

Moody's liquidity analysis attempts to understand the liability structure of the company, the options that may exist in the liabilities, and the degree to which the company's liabilities are confidence-sensitive. For life companies, when there is a high proportion of confidence sensitive policy holders, Moody's analyzes the company's assets. It considers an insurer's asset structure and its "cushion" of a large portfolio of liquid, marketable assets as well as alternative sources of liquidity for a company.

Moody's qualitative evaluation of an insurer also includes an assessment of its "franchise value", management and its organizational structure. In assessing an insurer's franchise value, Moody's looks at its competitive position in its marketplace. This involves assessing the quality of the company's products and distribution systems, and whether its product or service is essential. Moody's

also will evaluate whether the company has sustainable competitive advantages in its key lines of business.

Moody's evaluation of management considers its financial track record in such areas as investment risk taking, profitability, and product innovation. Management's strategy, as measured by rapid growth or new business development, is also assessed. Moody's also examines an insurer's relationship to a parent, to subsidiaries or affiliate companies to assess their impact on the financial strength of the insurer. If an insurer is part of a holding company structure, its financial strength rating will typically be constrained by the senior long-term debt rating of the holding company.

Rating Classification & Distribution: Moody's uses the same symbols for its insurer financial strength ratings and bond quality ratings. The rating gradations are broken down into nine symbols, each symbol representing a group of ratings in which the quality characteristics are considered to be broadly the same. Numeric qualifiers (1-3) further distinguish insurance within the rating symbol. The rating symbols are divided into two distinct segments: strong companies (Aaa-Baa) and weak companies (Ba-C). Moody's rating symbols and descriptions are listed below.

Aaa: Insurance companies rated Aaa offer exceptional financial security. While the financial strength of these companies is likely to change, such changes as can be visualized are mostly unlikely to impair their fundamentally strong position.

Aa: Insurance companies rated Aa offer excellent financial security. Together with the Aaa group, they constitute what are generally known as high-grade companies. They are rated lower than Aaa companies because long-term risks appear somewhat larger.

A: Insurance companies rated A offer good financial security. However, elements may be present which suggest a susceptibility to impairment sometime in the future.

Baa: Insurance companies rated Baa offer adequate financial security. However, certain protective elements may be lacking or may be characteristically unreliable over any great length of time.

Ba: Insurance companies rated Ba offer questionable financial security. Often the ability of these companies to meet policy holder obligations may be very moderate and thereby not well safeguarded in the future.

B: Insurance companies rated B offer poor financial security. Assurance of punctual payment of policy holder obligations over any long period of time is small.

Caa: Insurance companies rated Caa offer very poor financial security. They may be in default on their policy holder obligations or there may be present elements of danger with respect to punctual payment of policy holder obligations and claims.

Ca: Insurance companies rated Ca offer extremely poor financial security. Such companies are often in default on their policy holder obligations or have other marked shortcomings.

C: Insurance companies rated C are the lowest rated class of insurance company and can be regarded as having extremely poor prospects of ever offering financial security.

Dissemination of Rating Information: Moody's disseminates its ratings through various publications and over the telephone. The public can obtain Moody's ratings, free of charge, by calling its public ratings desk. Moody's Life Insurance Credit Research Service includes detailed reports on insurers, special comments on the industry, and access to analysts. Moody's Life Insurance Handbook contains summary credit opinions of all rated life insurers.

FITCH RATINGS

Fitch Ratings, located in New York and London, is another well-known rater of securities that branched into rating insurers' financial strengths. Fitch has been providing investment research since 1913. They were the first to introduce the now familiar "AAA" to "D" ratings scale in 1924. A merger with IBCA (London) in 1997 followed by the acquisition of another well-known ratings company (Duff & Phelps) in 2000 brought worldwide presence.

These acquisitions strengthened Fitch's coverage in the corporate, financial institution, insurance and structured finance sectors. Fitch's philosophy and approach are similar to that of S&P and Moody's in terms of its risk assessment of insurers from the standpoint of insurance buyers. They emphasize a very thorough qualitative analysis along with quantitative analysis in conducting its rating evaluation.

A Fitch's claims paying ability rating reflects Fitch's opinion as to the likelihood of payment of policy holder and contract holder obligations in accordance with the terms of such obligations. Insurers apply to Fitch to obtain a claims paying rating and are required to pay an annual fee, in addition to agreeing to supply the necessary financial and other information. However, Fitch has rated carriers that did not apply for a rating. Insurers also can opt not to have their rating published although no company is currently in that status.

Rating Process: Insurers are subject to a thorough quantitative and qualitative evaluation in Fitch's rating process. The rating process starts with an application from the insurer. This is followed by a Fitch request for financial information including:

- Current year budget covering expected statutory performance, and, if available, current five-year projections with assumptions.
- Materials that will help to illustrate the asset/liability matching process, including investment policy and methods for estimating asset and liability durations.
- Current New York Regulation 126 filing.
- Listings of problem loans/assets for each major asset class.
- Organizational charts covering corporate structure and principal executive reporting lines.
- Descriptive materials concerning key products.
- Strategy statement by product line.
- Distribution of bond assets by quality ranking, industry category and other categories perceived to be important.
- History of the company focusing on major milestones.
- Any available relative industry comparison statistics on investments, expenses, market share, etc.
- Long form (including all schedules) annual statements for most recent six years. Separate annual statements for subsidiary organizations for most recent year.
- Separate account statements for most recent two years. Separate account statements for subsidiaries for most recent year.

- Quarterly statutory statements for current and preceding year. Also, subsidiaries' quarterlies.
- Most recent insurance department triennial examination report.
- Annual shareholder reports, 10Ks (current and preceding year 100s) for most recent six years and current proxy and recent prospectus.
- Most recent two years audited SAP and GAAP financial statement for entity being rated.
- Annual policy holder reports for most recent two years.

After the information has been received, Fitch representatives visit the insurance company for an initial on-site interview. During that meeting, Fitch representatives talk with key management personnel including the chief executive officer, chief financial officer, chief investment officer, chief marketing officer and product managers. In special situations, company officials are also invited to Fitch headquarters in New York to meet with members of the Fitch rating committee.

Upon receiving the insurer's financial data, Fitch analysts conduct a number of tests that include comparative analysis and financial ratios in areas such as profitability, operating efficiency, investment risk, leverage and liquidity. The analysts also conduct an extensive qualitative evaluation of the company's management, competitive position, economic fundamentals, ownership structure and asset/liability management practices. There also is considerable cross comparison of quantitative and qualitative factors to reach an analytical judgement as to the financial condition of the insurer.

Upon completing their evaluation, Fitch analysts present a report and initial rating recommendation to the Fitch rating committee. The rating committee, consisting of 11 senior credit rating company officers, reviews the analysts' report and recommendation and determines a rating. The rating and an analysis is presented to the insurance company. The company has the option of not having the rating published, but currently no companies are in that status. Insurer ratings are then disseminated over the telephone, through electronic mail, press releases and Fitch publications. Insurers are also allowed to distribute their Fitch rating and report.

After its initial rating is completed, insurers are subject to ongoing review. This includes obtaining quarterly updates of financial information as well as annual reviews. In addition, Fitch insists on being informed of any significant developments affecting the company to be able to assess their impact and support the rating.

Rating Methodology: Analysis of an insurance company's claims paying ability is "closely allied" to credit analysis at Fitch. The process emphasizes analysis of the company's future ability to pay its policy and contract obligations when they are expected to come due. Confidence in an insurer's long-term solvency and its ability to maintain adequate liquidity are critical considerations in Fitch's review.

Fitch's assessment of an insurer's claims paying ability is based on both quantitative and qualitative analysis. Moreover, interaction between Fitch analysts, senior credit rating committee members and senior management of the company being rated is central to the rating process. Critical areas of analysis are an assessment of the rated company's capital adequacy and the ability to maintain adequate capital in future years; review of investment returns; review of the liability structure (principally statutory reserves) with heavy emphasis on the inherent stability of such liabilities; an assessment of asset and liability management practices including scenario testing in connection with controlling interest rate risk over a range of possible interest rate scenarios; a detailed review of liquidity management and "worst case" scenario testing; analysis of profitability, tax issues, product line returns, reinsurance relationships and marketing strategy; and an actuarial review of product design, pricing and performance together with interest rate crediting practice. In addition, historical,

current year-to-date and budgeted financial results are reviewed together with long-range strategic forecasts.

The purpose of this review and analysis is to develop a set of financial performance expectations for the company being rated reflecting the prospective nature of the rating. The subsequent monitoring of the assigned rating and a company's financial performance is a continuing process with actual financial performance regularly compared to expectations. Ratios included in Fitch's quantitative tests are:

- Return on Average Admitted Assets
- Return on Adjusted Surplus
- Net Investment Income Yield
- Combined Ratios
- Expense Ratios
- Surplus Formation
- Higher Risk Assets to Adjusted Surplus
- Investment in Affiliates to Adjusted Surplus
- Premiums to Adjusted Surplus
- Adjusted Liabilities to Adjusted Surplus

In determining adjusted surplus, Fitch sums a company's reported surplus, mandatory securities valuation reserve, deficiency reserves, and other balance sheet items which it considers to represent "capital" employed. Fitch's rationale on these adjustments is to identify and measure total capital employed and thus measure both profitability and operating leverage on a basis consistent with a company's economic reality. Surplus formation measures growth in adjusted surplus relative to the growth in adjusted liabilities.

A ratio of 1.00 indicates that adjusted surplus and adjusted liabilities are increasing at equivalent rates. A ratio of less than 1.00 implies increased use of operating leverage as the growth in liabilities exceeds the growth in adjusted surplus.

Fitch's rating evaluation also places considerable emphasis on qualitative factors including:

- Economic fundamentals of the company's principal insurance lines;
- Company's competitive position;
- Management capability;
- Relationship of the rated entity to either parent, affiliate, or subsidiary; and
- Asset and liability management practices.

Ultimately, Fitch's rating conclusions rest on integration of the quantitative and qualitative factors in a company's picture. In Fitch's view, the critical consideration in rating is the analytical judgment as to whether historical trends will persist or reverse themselves.

A company with sharply declining profitability measures would normally have a lower claims paying ability rating than a company with either lower and stable or lower and increasing profitability measures. Conversely, a company with higher absolute but stable leverage could receive a higher claims paying ability rating than a company with lower but increasing leverage.

Fitch also is very attentive to an insurer's sensitivity or exposure to both underwriting and business cycles. For example, it notes that the profitability of a life insurer's group accident and health business is typically very sensitive to competition induced rated inadequacy, inflation-driven increases in claim costs, and business cycle-related reductions in client company employment levels. Similarly, an insurer's assets and liabilities are highly sensitive to interest rate changes, which is the principal factor accounting for balance sheet volatility. Consequently, Fitch focuses on asset and liability mismatches and management techniques to control interest rate risk. It also is concerned with measuring the adequacy of a company's adjusted surplus relative to the effects of this volatility.

Finally, Fitch will weigh certain factors differently in making a rating judgment depending on the circumstances. A company with either demonstrated significant parent support or well above average stability as gauged by trend and volatility, the absolute level of leverage would normally take on less importance in reaching a rating decision than for a company for which these circumstances were not present.

Rating Classification and Classification Distribution: The rating scale that Fitch uses for its claims paying ability ratings is the same as the one it uses for bonds and preferred stock although different definitions of safety are used. Fitch's claims paying ability rating concerns only the likelihood of timely payment of policy holder and contract holder obligations and is not intended to refer to the ability of either the rated company, or as the case may be, a parent, affiliate, subsidiary, etc., to pay non-policy/contract holder obligations. A scale from AAA to CCC is used with "+" to "-" signs to further delineate quality within the broad alphabetical categories. Fitch's ratings and definitions are provided below.

AAA: Highest claims paying ability. Risk factors are negligible.

AA: Very high claims paying ability. Protection factors are strong. Risk is modest, but may vary slightly over time due to economic and/or underwriting conditions.

A: High claims paying ability. Protection factors are average, and there is an expectation of variability in risk over time due to economic and/or underwriting conditions.

BBB: Below average claims paying ability. Protection factors are average. However, there is considerable variability in risk over time due to economic or underwriting conditions.

BB: Uncertain claims paying ability and less than investment grade quality. However, the company is deemed likely to meet these obligations when due. Protection factors will vary widely with changes in economic and/or underwriting conditions.

B: Possessing risk that policy holder and contract holder obligations will not be paid when due. Protection factors will vary widely with changes in economic and underwriting conditions or company fortunes.

CCC: There is substantial risk that policy holder and contract holder obligations will not be paid when due. Company has been or is likely to be placed under state insurance department supervision.

Dissemination of Rating Information: Fitch disseminates financial and rating information on insurers through several means, including telephone inquiries, electronic transmission, press releases, company reports and two publications. The Insurance Company Claims Paying Ability

Rating Guide, issued quarterly, contains detailed reports, financial information and ratings for all Fitch rated insurers. There is also a monthly Rating Guide which provides claims paying ability ratings for insurers as well as ratings for long-term and short-term debt instruments and preferred stock. In addition, the public can telephone Fitch free of charge to obtain insurer ratings and an explanation of what the ratings mean.

WEISS RESEARCH

Weiss Research, located in West Palm Beach, Florida, is somewhat different from the other insurance company raters discussed in this paper in terms of its approach. Its founder, Martin D. Weiss, has been publishing newsletters about money markets, interest rates, bank safety and economic forecasting since 1971. In 1989, Weiss began publishing "safety ratings" of life, health and annuity insurers.

Weiss' methodology and rating scale has generated some controversy within the industry. Weiss' safety rating indicates its opinion regarding an insurer's ability to meet its commitments to its policy holders not only under current economic conditions, but also during a declining economy or in an environment of increased liquidity. A computer model comprised of some 200 financial ratios is used to determine an insurer's rating.

The data for the model is obtained from statutory statements and other supplemental financial information provided by insurers. Weiss stresses that it bases its analysis exclusively on objective, quantifiable information. It eschews interjecting subjective and unquantifiable judgment into the rating process. Consequently, unlike other raters, Weiss does not interview insurer's management nor utilize other subjective information.

Weiss believes that good management will produce good results and that bad results cannot be explained away by management. Weiss' ratings are essentially involuntary. Insurers do not apply to Weiss for a rating, nor do they pay a fee for being rated. Weiss supports its insurer rating activities through the sale of its rating information to the public. Weiss believes that this approach allows it to be independent in its rating evaluation.

A more detailed description of Weiss' rating process, methodology and classification scheme follows.

Rating Process: Weiss follows a five-step process to arrive at a rating. The process begins with data collection. Weiss obtains quantitative information on insurers from several sources including 1) statutory data in computerized form from the NAIC; 2) statutory annual and quarterly data not provided by the NAIC; 3) supplemental data from surveys sent to the companies; and 4) additional data supplied by the companies.

The next step in the process is data validation. This involves running crosschecks on data to identify errors, which are corrected by reference to the hard copy statement or by contact with the company. Data is then mailed to the companies for validation. The next steps are ratio analysis and modeling. The modeling procedure involves automated generation of ratings through a hierarchical series of calculations involving weighting, capping and filtering of the ratios.

Weiss describes its rating system as a pyramid. At the top of the pyramid is the overall rating. This rating is composed of several indexes. Each index, in turn, is derived for a series of "components". The components are based upon several "subcomponents". The subcomponents are derived from the statutory data and data from the companies. The last step is "reality checking". This involves

manual verification of the results and modifications of the overall model so that all companies are affected fairly.

The results of Weiss' analysis and its ratings are sent to the companies with a request that the data be examined and verified. Some companies do not respond to these requests and others may object to the rating. Insurers are invited to visit Weiss Research to discuss the rating methodology and conclusions. Insurers are requested to provide new, objective and verifiable information, which will be put into the process and evaluated along with other data.

Once finalized, Weiss ratings are communicated over the telephone and through several publications and software to consumers, agents and others. Review of the insurer also continues. Weiss Research receives quarterly reports from the insurance companies. New information is added to the analytical process and is reported in quarterly updates.

Rating Methodology: Weiss' rating model utilizes five key indices: 1) risk adjusted capital; 2) profitability; 3) liquidity; 4) spread of risk; and 5) sources of capital. Weiss utilizes two risk adjusted capital ratios to determine a company's exposure to investment liquidity and insurance risk in relation to the capital the company has to cover those risks.

The first risk adjusted-capital ratio evaluates the company's ability to withstand a moderate-economic decline. The second ratio evaluates the company's ability to withstand a severe economic decline. To calculate these risk-adjusted capital ratios, Weiss sums all of the company's resources that could be used to cover losses. These resources include capital, surplus, MSVR, and a portion of the provision for future policy holders' dividends, where appropriate. Additional credit may also be given for the use of conservative reserving assumptions and other "hidden capital" when applicable. Next, Weiss determines the company's target capital.

This answers the question: Based on the company's level of risk in both its insurance business and its investment portfolio, how much capital would it need to cover potential losses during a moderate economic decline? For Weiss, an average recession is one in which the real gross national product (GNP) declines by about the same amount as it did in the postwar recessions of 1957-58, 1960, 1970, 1974-75, 1980 and 1981-82.

The first risk-adjusted capital ratio is equal to capital resources divided by target capital. If a company has a risk-adjusted capital ratio of 1.0 or more, it means the company has all of the capital Weiss believes that it requires it to withstand potential losses which could be inflicted by a moderate economic decline. If the company has less than 1.0, it does not currently have all of the basic capital resources Weiss thinks that it needs.

Weiss notes that during times of financial distress, companies often have access to additional capital through contributions from a parent or holding company, current profits or reductions in policy holder dividends. Therefore, an allowance is made in the rating system for firms with somewhat less than 1.0 risk-adjusted capital.

The second risk-adjusted capital ratio is equal to capital resources divided by target capital calculated under conditions of severe economic decline. According to Weiss, a severe recession is a prolonged economic slowdown in which the single worst year of the postwar period is extended for a period of three years. This ratio is then converted into an index measured on a scale of zero to 10, with 10 being the best and seven or better considered strong.

A company whose capital, surplus, MSVR and other capital reserves equal its target capital will have a risk-adjusted capital ratio of 1.0 and a risk-adjusted capital index of 7.0. Weiss' profitability index also is a major factor in measuring the financial strength of an insurer and is derived from an analysis of the following five components: 1) the adequacy of investment income; 2) average and weighted average of net gain on operations over the past five years; 3) volatility of operating gains; 4) contribution of gains to capital growth; and 5) control over expenses, in relation to anticipated norms.

The adequacy of investment income to meet the interest requirements of policy reserves is measured in the same way as IRIS ratio 4. It compares the interest credited to life and annuity, health and deposit funds (such as GICs) with the company's investment income to determine whether the company's investment income adequately covers its needs. If income levels are inadequate, the rating will be adversely impacted.

Significant margins above the break-even point have a positive impact on the profitability index. The average and weighted gain on operations look at the overall profit levels of the company over a five-year period. They are measured in terms of return on assets and return on equity. Weiss looks for stable, consistent profits and does not give additional credit for return on equity figures above the 7.5 percent level. A subcomponent is the difference between the straight average and weighted average of net gains. This reveals the profit trend.

If the weighted average is greater than the straight average, profits are generally improving. An up-trend favorably affects the profitability index, helping to offset the negative impact of net loss in the current period. Conversely, a downtrend with marginal current profits may have a negative impact on the profitability index. With respect to volatility of profits, credit is given for a low standard deviation. Conversely, large swings in operating results are viewed negatively. Additionally, volatile operating gains "are viewed as a possible Indicator of surplus relief insurance. Additional deductions are made for weighted aggregate operating losses over the last five-year period.

The sources of a company's capital are viewed as an important barometer of a company's financial health. Weiss believes that a company should fund its growth internally from its profits. Contributions from stockholders and/or parent corporations and capital gains are also considered positive factors. However, gains from surrenders, large amounts or reinsurance with non-affiliates and changes in reserve valuation basis are viewed negatively. These and other sources of capital are weighted to produce an index that measures the quality of capital sources. Weiss sees control over expenses as a key indicator of management's skill in controlling operations.

In the Weiss analysis, based on studies by the Canadian Institute of Actuaries, average expenses are derived by function and by line of business. A mean cost figure is derived based on a series of unit costs. For each company, the number of units is multiplied by the average unit cost, which, in turn, is compared with that of all the other companies. If total expenses are more than 100 percent of the standard, it indicates a less than average efficiency of operations, negatively affecting the profitability index. If they are less than 100 percent, it indicates a greater than average efficiency positively affecting the index.

Weiss' liquidity index compares: 1) the company's liquid assets; 2) illiquid assets; 3) cash flows to its potential liquidity needs. The following are the subcomponents of each of these components:

- Liquid assets include cash and marketable securities, such as bonds with maturities of less than one year, publicly traded bonds of investment grade and common or preferred stock.
- Illiquid assets include items such as real estate, mortgages and investments in affiliates.
- Cash flow items include premiums and investment income less benefits and other expenses.
- Subcomponents affecting potential liquidity needs include:
- Liability for interest sensitive products (e.g. GICs, deferred annuities and other deposit funds), depending on cash-out provisions;
- The company's surrender experience;
- Market value adjustments; and
- Surrender fees as disincentives for disintermediation.

The spread of risk factors utilized by Weiss include: size of investment portfolio; distribution of net premium and deposit funds by line of business; number of policies and contracts in force; and retention limits on ordinary and group life and use of reinsurance. Sources of earnings/capital include: operations (retained risk); reinsurance; investment earnings; realized capital gains; unrealized capital gains; capital infusions; paper adjustments (changes in MSVR, reserve valuation basis, etc.); and appropriateness of dividend levels (policy and stock).

Weiss' investment safety index utilizes risk and liquidity calculations separate from those used in the risk-adjusted capital ratios. Weiss' model considers investment yields, bond default rates, mortgage non-performance rates and portfolio diversification. The process evaluates the relative risks in each investment category and considers these in relation to a company's resources for dealing with them. Exceptional values are noted and analyzed to determine its relevance to a company's financial strength.

Weiss does not allow subjective judgments to alter a factual interpretation of the data. However, there are factors which other raters might treat as qualitative which are quantified in Weiss' system. For example, the New York Regulation 126 filing is analyzed in terms of the severity of the underlying assumptions used and the results of the scenario testing in terms of their impact on profits and capitalization. These are then carried over to the interest-rate risk factors in the risk-adjusted capital equation and other equations.

Another example is where the nature of the policy-loan provisions in each company's contracts is quantified in the risk factor associated with policy loans in the risk-adjusted capital calculation. Also, the impact of mergers, acquisitions and other special historical circumstances on mechanical ratios are factored out with filters tailored to the particular situation and then used for all companies falling into a similar category.

Weiss also measures the quality of management through quantitative analysis of historical data on past performance. Areas evaluated include: cost control skills; bond portfolio management skills; mortgage portfolio management skills; asset-liability management skills; and profitability management skills as measured by current and recent trends.

Rating Classifications and Distribution: In Weiss' view, the rating of an insurer's financial health should reflect the probability of that company meeting claims in the future as well as its probability of insolvency. Its objective is to place companies in a risk-class that accurately describes the likelihood of insolvency.

Weiss' basic rating scale ranges from A to F with "+" and "-" modifiers. A"+" sign indicates that, with new data, there is a modest possibility that this company could be upgraded. The A+ rating is an exception since no higher grade exists. A"- " sign indicates that, with new data, there is a modest possibility that the company could be downgraded. In addition, companies with less than \$25 million in capital and surplus are designated with an "S" in front of their alphabetical rating. The "S" is simply a reminder that consumers may want to limit the size of their policy with this company so that the policy's maximum benefits do not exceed one percent of the company's capital and surplus. Also, companies receive an unrated classification U if: 1) total assets are less than \$1 million; 2) premium income for the current year is less than \$100,000; 3) the company functions almost exclusively as a holding company rather than as an underwriter. Weiss' basic ratings are listed below with their definitions.

A Excellent: This company offers excellent financial security. It has maintained a conservative stance in its investment strategies, business operations and underwriting commitments. While the financial position of any company is subject to change, Weiss believes that this company has the resources necessary to deal with severe economic conditions.

B Good: This company offers good financial security and has the resources to deal with a variety of adverse economic conditions. However, in the event of a severe recession or major financial crisis, Weiss feels that this assessment should be reviewed to verify that the firm is maintaining adequate financial strength. Carriers with a rating of B+ or higher are included on Weiss' recommended list of companies.

C Fair: This company offers fair financial security and is currently stable. But, during an economic downturn or other financial pressures, Weiss feels that it may encounter difficulties in maintaining its financial stability.

D Weak: This company currently demonstrates what Weiss considers to be significant weaknesses that could negatively impact policy holders. In an unfavorable economic environment, these weaknesses could be magnified.

E Very Weak: This company demonstrates what Weiss considers to be significant weaknesses and has also foiled some of the basic tests used to identify fiscal stability. Therefore, even in a favorable economic environment, it is Weiss' opinion that policy holders could incur significant risks.

F Failed: Company is under the supervision of state insurance commissioners. The distribution of Weiss' ratings tends to be more bell-shaped with more insurers receiving average or below average ratings than assigned by other raters. A recent sample distribution of Weiss' ratings showed that of the 1,470 insurers receiving a letter grade, only 3.8 percent received an A grade and only 15.2 percent received a B grade. Of the rated insurers, 48.2 percent received a C grade and 32.8 percent received less than a C rating.

Dissemination of Rating Information: Consumers and agents are able to obtain a verbal rating over the telephone from Weiss for a charge. Consumers also can order an Insurance Safety Directory issued quarterly for all life and health insurance companies. The Directory Includes key financial data and ratios for each company and a list of recommended companies with a rating of B+ or higher.

SUMMARY ON RATING SERVICES

There is a good deal of similarity among the rating agencies in terms of their basic objectives and approaches in evaluating the financial strengths of insurers. Their essential objective is to assess and offer an opinion as to the ability of an insurer to meet its obligations to policy holders. With the exception of S&P's qualified solvency ratings and the Weiss' safety ratings, the raters utilize both qualitative and quantitative analysis, apply certain basic principles, and follow similar rating processes. At the same time, there are differences among the raters, and they sometimes issue different rating opinions of the same insurers.

Rating the financial strength of an insurer is inherently a complex process, and there is considerable opportunity for variation. In terms of quantitative analysis, raters differ with respect to the specific financial ratios used; adjustments to data or ratios to reflect reserve adequacy, reinsurance quality, investment quality, ownership structures and other factors; the weights or significance attached to different financial ratios; and ultimately the way in which quantitative information is utilized in an insurer's overall evaluation.

Qualitative analysis provides even greater opportunity for different evaluations among the raters. Assessing the implication of qualitative factors for a company's financial strength, particularly over a long time horizon, inherently involves a considerable amount of subjective judgment. That subjectivity inevitably can result in at least marginally and sometimes significantly different rating conclusions.

Rating opinions are also affected by somewhat different rating philosophies. The securities rating firms essentially assess the risk that an insurer will not be able to meet its obligations to policy holders. Weiss also assesses an insurer's risk to policy holders but bases its assessment on more pessimistic economic scenarios than other raters. Alternatively, AM. Best places greater emphasis on prevention than detection of insolvencies. For that reason, Best may exhibit greater patience than other raters in allowing a company to resolve its problems before downgrading it.

Insurance company ratings which are based strictly on statistical analysis - S&P's qualified solvency ratings and Weiss Research's safety ratings - fit into a special category. The primary advantages of quantitative ratings are that they cost less to perform and do not require the insurers being rated to cooperate. The agencies that issue quantitative ratings contend that they expand the availability of unbiased information to consumers.

Critics complain that quantitative ratings do not consider various qualitative factors that could explain adverse statistical results. Weiss responds that its approach avoids influence by company management to reach a more favorable rating determination than what the company's actual results suggest. However, in theory, qualitative considerations could also result in a less favorable rating. Indeed, it is difficult to argue with the fact that quantitative ratings are inherently more limited than ratings that consider qualitative information as well as quantitative information.

From a public interest standpoint, the issue boils down to whether the benefits gained from having additional rating opinions available, albeit statistically based, outweigh any costs that inure from their limitations. This analysis did not evaluate which rating philosophy or methodology was better or worse. Each rater offers support for its particular approach.

We also did not attempt to assess the accuracy of ratings by looking retrospectively at how failed insurers had been graded by different raters prior to the insurer's failure. Ideally, such an assessment would consider accuracy in identifying financially strong insurers, as well as financially weak insurers. This is easier said than done because the fact that a low rated insurer has not failed does not necessarily mean that the low rating is not justified or that the insurer will not ultimately fail.

The emergence of additional raters during the 1980s responded to a perceived demand for more information and alternative opinions about insurers' financial strength. There seems to be fairly unanimous agreement that the availability of multiple rating opinions benefits consumers, even if there is disagreement about how these opinions should be formulated.

There are also different opinions about the ability of the users of rating opinions to evaluate the validity of those opinions and to sort good methods from bad ones. Some believe that regulators should intervene to prevent the supply of misinformation while others would prefer to rely on the market to sort good information from bad information.

RATING CHANGES

Agents, however, should, always be prepared for new regulatory environments coupled with diminished profits and the need for rating agencies to clamp down. Ultimately, this will affect ratings. While there are no wide scale insolvencies anticipated, deteriorating conditions eventually affect client confidence.

Marketing products and services in the face of reduced ratings will test agent due diligence and company selection skills beyond any previous limits. Be careful, back up your reasons for moving clients from one insurer to another, especially if the new insurer ratings' decline. In a period following major company failures it is also logical that the rating agencies will emerge with new, tighter criteria. They must also adapt to changing regulatory laws and formulas. Needless to say, major changes can occur at any time.

A preview of the intensity and breadth of change possible took place in July 1993 when A.M. Best shocked the insurance world by downgrading over half of the life companies who previously held A+ or A++ ratings to A. Before this, in late 1992, Best added six new letter ratings (A++, B++, C++, D, E and F). This increased the ratings of this firm from 9 to 15. It also brought to light the huge differentiation the company anticipates in company ratings. Further, it could be a indication that the company will no longer be timid in swiftly downgrading a company.

In an article, Best explained its rating modifications: 'The purpose of these changes was to enhance the usefulness and clarity of our rating system. More important than the structural changes to Best's rating classification has been the continuing evolution of our analytical review. Specifically, qualitative considerations have become increasingly important in Best's rating system'.

Some feel that the Best downgrades are tied to size of company. One company's analysis showed that 77 percent of the 71 companies adjusted downward had assets less than \$600 million. Best contends that its rating framework is the same for all companies, regardless of size. They do admit, however, that there are advantages to size in certain lines of business.

According to the company administrative capabilities, technological advantages, lower unit costs and management depth can provide competitive strengths that contribute to market penetration and

presence difficult to achieve in highly competitive businesses on a relatively small scale. Though such advantages may be reflected in rating assignments, smaller companies that remain highly focused and maintain sustainable and defensible strengths also fare favorably in Best's rating assignments.

Other rating services will also recognize the need to adapt their solvency formulas. In the past, some of these companies, namely Standard & Poors and Weiss, have based their analyses primarily on quantitative issues such as the insurer's claims-paying ability based on statistics generated from statutory filings with individual state insurance departments or the National Association of Insurance Commissioners.

With new risks of regulatory violations, competition from new entrants, banks, thrifts, etc, and the delicate line insurers must walk between solvency and profit, it is likely these agencies will add fresh information to modify their approach. Few raters, with the exception of Moody's, have focused on the breadth of such issues. This is likely to change in the years ahead with the inevitable result being lower ratings.

Experts believe that one financial signpost to watch is the variation in a company's rating or a frequency in downward ratings. If an insurer's rating varies widely between rating companies, this could be concern.

Industry Benchmark Tools

In recent years, the industry has experienced a small taste of the new regulatory "bite". Despite huge insurer losses from hurricane and Midwest flood claims, regulators in these states prohibited major rate hikes and required companies to continue providing coverage. In Florida, consumer outcries prompted the state legislature to initiate a moratorium on "non-renewals" and limit annual rate increases to five percent when an increase of 20 percent is needed to recoup from hurricane losses.

The liquidity problems of life insurers are also a definite target for regulators. So great is the pressure and so many are the proposals that life companies are totally consumed with restructuring for regulatory solvency to the detriment, some say, of passing on investment opportunities that could mean substantial earnings in years ahead. The management of profitability under these conditions runs a clear second to solvency issues. This could place life companies at a competitive disadvantage to banks and other financial services industries, where solvency issues have improved and profitability is again the first priority.

Risk Based Capital

Risk Based Capital is the creation of the National Association of Insurance Commissioners. Since its inception, the National Association of Insurance Commissioners has strived to create a "national regulatory system" by the passage of "model acts", or policies designed to standardize accounting and solvency methods from state to state.

Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners. The National Association of Insurance Commissioners can be considered a logical conduit for national regulation, since its members are the insurance commissioners of each state and at present, the authority of states to regulate the insurance industry is allocated to the states under the 1945 McCarran -Ferguson Act.

Risk Based Capital defines acceptable levels of risk that insurance companies may incur with regards to their assets, insurance products, investments and other business operations. Insurers will be required, at the request of each state insurance department, to annually report and fill out Risk Based Capital forms created by the National Association of Insurance Commissioners.

Formulas, under Risk Based Capital, will test capitalization thresholds that insurers must maintain to avoid regulatory action; recalculate how reserves are used; reduce capitalization required for ownership of affiliated alien insurers and non-insurance assets; and allow single state insurers to qualify for exemption from reinsurance capitalization if their reinsurance doesn't exceed five percent of total business written.

The Risked Based Capital system will set minimum surplus capital amounts that companies must meet to support underwriting and other business activities. Because the standards will be different for each company, the guidelines run counter to existing state-by-state regulations that require one minimum capitalization require. Insurers reporting Risk Based Capital levels of say less than 70 percent to 100 percent may be subject to strict regulatory control.

Scores from 100 percent to 150 percent might be issued regulatory orders requiring specific action to cure deficiencies. Higher scores might receive regulatory warnings and corrective action stipulations. Attaining 250 percent or more, would relieve an insurer from any further Risk Based Capital requirements in a given year. It is clear that Risked Based Capital encourages certain classes of investment over others. For example, an asset-default test under Risked Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts-could be as much as 30 percent for stocks and tow quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages.

Industry critics say that the C-1 surplus requirements alone could be far greater than all other categories of Risked Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks. Many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings.

Despite these efforts, G1-rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market continues soft. A Saloman Brothers Inc. study of almost 500 insurance companies clarifies the problem. Financial reports for these insurers, the median level of surplus capital was found to be at 189 percent of their respective risked based capital levels. Even though, a majority of companies exceeded the 150 percent threshold-4hus, not requiring regulatory correction-the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when risked based capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risked Based Capital ratios.

On the surface, Risk Based Capital seems to solve many regulatory concerns. Solvency rulings are standardized from state-to-state and specific action is mandated across the board. This would appear to be acceptable by insurance companies who could now predict regulatory response in any state. However, as we have seen, Risked Based Capital could also adversely affect financially sound companies simply because they own more real estate.

Risk based capital also scores low among insurers for another very important reason. Risk Based Capital Reports can be disclosed and misunderstood by the public, despite National Association of Insurance Commissioners' confidentiality promises. It is easy to realize that disclosure concerning a low scoring company could damage or cause a "run" on the insurer. The National Association of Insurance Commissioners feels it has adequately provided for confidentiality within the Risk Based Capital Act. Specifically, the Model prohibits anyone in the insurance industry from using Risk Based Capital data and analysis in any public statement.

There is even a provision recommending that state legislatures exempt Risk Based Capital information received from the National Association of Insurance Commissioners from state "freedom of information" laws. Insurers doubt that any such exemption from disclosure will suffice, since few states have adopted any exemption legislation, and there is history that pressure from public, political and judicial arenas ultimately leads to access by anyone for any reason. In fact, there may be reason for insurance company concern about disclosure of Risk Based Capital data.

Recently, there have been attempts to retrieve information similar to Risk Based Capital data by an insurance journalist/analyst using "freedom of information" statutes. Many states denied the requests for reports; called IRIS ratios (Insurance Regulatory Information System reports) since this data is considered confidential by state financial examiners. Yet, in some states, the same requests for information had mixed success via direct court action. In response, the National Association of Insurance Commissioners adopted a policy to withhold IRIS report information from states that could not assure confidentiality.

Once information is demanded and then delivered to state regulators it becomes potentially fair game under freedom of information statutes. In a similar vein, there is concern that federal political pressure to subpoena confidential records of an insurer would allow even greater access since federal "freedom of information" statutes are typically more liberal than individual states. Safeguards proposed by the National Association of Insurance Commissioners and state regulators may help forestall public access, but it may be optimistic to think that a foolproof method to avoid disclosure is possible.

Troubled insurers, may well brace themselves for the likelihood that data on their Risk Based Capital could make national news or influence their ratings. Some, in the industry, also feel that the Risk Based Capital rules are simply too restrictive, subjecting many of the best known insurers to immediate regulatory action and/or "bad press". This, in turn might lead to a "run on the bank" that could tip these insurers into worse condition. The concern of these parties is that the risk based capital system doesn't falsely identify adequately capitalized insurance companies and undercapitalized ones as being adequately capitalized. Too much is concerned with the type of investment, rather than its quality. Just how companies react to these guidelines remain to be seen. As mentioned, many life and health insurers have already changed their investment strategies to more favorably align with Risk Based Capital guidelines by selling their large scale real estate investments and junk bonds.

Solvency & Financial Enforcement Trust (Safe-T)

In the search for a solvency "cure", it is possible that simple is better. Nothing could be simpler than a proposal called "Solvency & Financial Enforcement Trust" or SAFE-T for short. SAFE-T is considered a simple, straightforward solution because it eliminates the complex formulas proposed by many

other plans, such as the National Association of Insurance Commissioners "Risk Based Capital" plan. Developed years ago by State Farm for use by property/casualty companies, the SAFE-T method would require each insurer to fund a custodial account at an institution that is not related or affiliated with the insurer.

The funding of this account would be accomplished using real, liquid assets. The amount of assets in the account would be sufficient to cover loss reserves and loss adjustment expenses. To facilitate claim payments from an insolvent insurer, the guaranty fund for a particular state has, in essence, a lien against the SAFE-T trust account. The value of assets in the custodial account would be verified annually by a Certified Public Accountant along with a certification of loss reserves. More recent amendments to the proposal allow the insurer to retain all ownership rights to the assets in the custodial account, as well as the rights to sell and trade them, so long as any securities meet qualifying standards under the act.

Only cash, cash equivalents, publicly traded securities classified by the National Association of Insurance Commissioners as medium or high quality would be accepted. Also, an insurer could submit an approved letter of credit to meet assets requirements. The amount of this letter of credit, however, could not exceed 15 percent of the amount required to be on deposit in the SAFE-T account. Further, an insurer would be provided some leeway if the value of the assets in the account dropped during the year.

So long as assets maintained 80 percent of the required value, the insurer would not be required to add more assets in the middle of the year. If, however, the value drops below 80 percent of the required amount, the insurer must immediately respond with additional asset deposits or risk a "cease and desist" order restricting the company from writing any new business. Custodians of the SAFE-T accounts would be responsible for reporting to the respective insurance commissioners the activity and value of the insurer's account.

In the event insolvency was imminent, the SAFE-T account would be available to make prompt claims or to reimburse the state guaranty fund. The advantages of the Solvency & Financial Enforcement Trust are many. First, many of the standards, such as the use of Certified Public Accountants and certification of loss reserves, are already in place. This will enable easier set up and enforcement. Second, SAFE-T is based on the use of assets considered by many, including the National Association of Insurance Commissioners, to be the most valuable to an insurer's ability to meet its obligations to its policy holders. Third, the requirements of SAFE-T seem to align with the needs of state regulators looking for an improved "early warning" system that could be enforced without the need to apply complicated formulas and legal hoops. And, fourth, the number of insolvencies may be minimized, since liquid assets of the company will be controlled by the custodian.

In past cases, by the time an insurer faced insolvency, most of the liquid assets had already been sold, leaving less valuable and illiquid ones to the liquidator, state guaranty fund and policy owners.

The Compact Approach

Another approach to solvency regulation is to improve the existing state guaranty system. One proposal by the National Conference of Insurance Legislators seeks to provide a uniform set of standards for all state guaranty fund regulators. This would be accomplished by creating an interstate "compact" or agreement among all states to standardize the protection provided by guaranty funds, as well as procedures to rehabilitate and/or liquidate an insolvent insurer.

The idea of a "compact" between states is nothing new. Article 10 of the Constitution provides for a mechanism for states to make agreements among themselves in order that fair treatment of the citizens be served. This has resulted in over 100 interstate compacts over the years on issues like taxes, vehicle laws and crime.

There is no reason this wouldn't work to overhaul the current state guaranty systems which are riddled with loopholes, exclusions and diverse protection limits. It is common knowledge in the industry and among regulators that improvements to the system are needed, especially in the aftermath of public hearings presented to members of Congress in the early 90's. Significant weaknesses in the guaranty fund system were discussed, and the fear among industry leaders and regulators alike is that a lack of action to respond with corrective action may result in efforts to replace the state guaranty system with a federal mandate.

State fund problems aired in the public hearings include guaranty limits, insurer and policy owner residency and specific product exclusions. -Guaranty fund limits vary widely between states. Some funds will only cover residents of their state, others will back anyone insured by a company that is domiciled in the state. Additional variations include service and product coverage. Some funds guarantee all annuities written by domiciled companies while others exclude variable type policies. Some cover HMOs and Blue Cross/Shield plans, while others do not.

The National Association of Insurance Commissioners developed "model acts" which it hoped most states would follow: The Post-Assessment Property and Liability Insurance Guaranty Association Model Act (1969) and the Life and Health Insurance Guaranty Association Model Act (1970). The property/casualty model sets maximum limits at \$300,000 for any claim with unlimited coverage for workers' compensation. The life/health model includes maximum benefits of \$100,000 in cash values of life, annuity and health contracts and \$300,000 in death benefits.

The interstate "compact" proposed by the National Conference of Insurance Legislators could potentially smooth out the differences among states and bring about a set procedure for handling insurance company insolvencies. The proposal suggests this could be accomplished by creating a commission, called the Insurance Claimant Protection Commission, to coordinate the activities of all state funds participating in the compact and act as the receiver of insurers placed in rehabilitation or liquidation.

The commission would be comprised of the commissioner of each state. Each state would have one "member vote", as well as a designated number of "premium votes", based on the state's total premium volume. Any decision by the commission would require a majority of both member and premium votes. Commission meetings would be public, unless a majority of members agreed that subjects discussed would reveal trade secrets or confidential information.

Funding of the commission would be through assessments of insurance companies doing business in the compact states. Reports would be made annually to the governor and legislature of each state as well as the National Conference of Insurance Legislators. Regulations and statutes approved by the commission would be binding on all state funds in the compact. As an escape measure, each state's legislature could vote to reject a commission statute. If a majority of states follow suit, the specific regulation would have no force and effect on any compact participant.

Under the threat of federal intervention, it is likely that the interstate compact should attract major attention. Already, insurance departments of several states are amenable to working on a compact

plan and the National Conference of Insurance Legislators is in process of contacting state legislators, policymakers and industry trade groups. The fact that the interstate compact was conceived by state legislators with technical assistance from one of the nation's top insurance law firms give it a greater chance of success than many other solvency proposals.

Federal/State Co-Regulation

On the heels of several large insolvencies, a flood of regulatory initiatives have emerged. Critics of the new proposals say there is no panacea for the problem of insolvencies. Even federal intervention will not bring an end to insolvencies, since they are inevitable in a free market. Then, too, the federal government does not have a stellar record in the area of efficiency and regulatory success. Others, however, believe that federal involvement in the regulation of insurance is necessary to industry stability and the centralization of authority. While there is cause to doubt this last proclamation, it is possible that some form of federal and state system of regulation will be attempted.

The Federal Insurance Solvency Act of 1992 is one such form. Under this act, a solvency commission is established to regulate all insurers. Insurance companies and reinsurers receive the equivalent of a "solvency certificate" which would permit them to do business anywhere in the United States. The bill also creates a protection or guaranty fund to cover any insolvency losses.

Some believe that a slightly different "two-tiered" system can work. Federally licensed companies could do business alongside state licensed insurers much like they do in the banking industry where some institutions are federally chartered while others operate solely under the jurisdiction of the state. Insurers, both large and small, could have the choice to be federal or state licensed and limits on guaranty funds could be standardized. Additionally, an insurer could and should be totally regulated by either the federal or state system, not partially regulated by both.

The advantages, of such a system, key on uniformity for the insurer wishing to do business on a nationwide scale. Policy owners would also know that guaranty fund limits are the same from state to state. One would wonder, however, if such a system would favor federally licensed companies where policy owners might feel a federally backed guaranty fund is safer than a state fund. It is suggested, then, that for a successful federal-state system to exist, competition must be eliminated. That is why many industry regulators and players believe that anew, untried federal system is not practical. They argue that in place of scrapping state systems of regulation, a major restructuring of existing state guaranty funds and universal solvency rules would have greater value. Thus, proposals like Risk Based Capital, SAFE-T and the Interstate Compact must be seriously considered to "head off" federal intervention.

Model Investment Laws

The National Association of Insurance Commissioners has also made headlines for its Model Investment Laws. The purpose of these regulations is to prevent insurance companies from concentrating too much cash in too few types of assets. Critics feel the National Association of Insurance Commissioners' guidelines rely too heavily on classifying by type of investment and risk and setting percentage maximums.

National Catastrophe Fund

Although it may be years in the making, a National Catastrophe Fund is also being considered. During hearings before the Senate Commerce, Science and Transportation Committee, details indicate that this fund would reinsure existing companies to ease the impact of major disasters. A company with losses that exceeded 20 percent of its surplus would qualify for assistance. Because only regional and small companies are likely to collect from such a federal fund, the current thinking is that the amount of losses would not be large enough to seriously strain the fund.

State Catastrophe Funds

Regulators have and will be influential in convincing state legislatures to establish catastrophe funds. These funds may start out to be permanent solutions only to fizzle out within months or years after the disaster has struck. Current efforts include Hawaii and Florida, where major hurricanes have hit in the 1990s. In Hawaii, the state hurricane fund is the exclusive provider of hurricane insurance.

The programs are financed through a variety of real estate fees, premium taxes and assessments. The systems function as a reinsurer to companies writing within the catastrophe zone Florida's hurricane trust fund will reimburse insurers for 75 percent of their losses once claims surpass two times the amount of the company's annual premium. Financing of the program will be through surcharges on policies, a percentage of premiums written, emergency assessments and state guaranteed bonds.

Financial Solvency Analysis

There are as many theories as there are people analyzing insurance companies. Favorite ratios are: Technical Analysis: A former insurance commissioner, Bruce Bunner, proposed five financial formulas producers could use themselves to test for carrier solvency. Bunner noted that agents and brokers are not expected to be experts in the financial analysis. "Nevertheless, a producer does have a moral response", said Bunner, "to perform reasonable due diligence procedures with respect to the financial credibility of insurance companies being used to underwrite clients' risks."

Bunner feels that financial ratios in and of themselves are not a panacea. They can, nevertheless, serve as guideposts to identify positive and negative financial trends and the comparative health and stability of a company within the industry. Further, "when the evidence clearly indicates that a company's financial condition is deteriorating, too many agents and brokers continue to place their customer's risk with the same company. When price alone is the only marketing consideration and the producer disregards emerging negative financial signals, the agent is doing an extreme disservice to his client, and as such, must morally share some culpability with company management when and ensuing financial debacle occurs."

Bunner's five ratios are simple to calculate and the necessary company financial data is readily available to the public in the annual statements on file at each state's department of insurance. The suggested formulas are: Gross premiums written to surplus; Two Year operating ratio; Surplus to admitted assets; Loss and expense reserves to surplus; and, The acid test.

Gross Premiums Written to Surplus: This is a variation on the National Association of Insurance Commissioner's IRIS test ratio (Insurance Regulatory Information System) which compares net

premiums written to surplus. The National Association of Insurance Commissioner's IRIS test guideline considers a result of 3 to 1 as acceptable. Bunner feels 2.5 to 1 as preferable. Further, he believes that the IRIS test ratio should be expanded to compare gross premiums written to surplus rather than net premiums written to surplus.

Gross premiums written in excess of 4 to 1 surplus should be considered unacceptable. Further, Bunner feels that the relationship of gross written premiums to surplus is more important because the National Association of Insurance Commissioners IRIS test fails to consider the effect of disproportionate reinsurance activity. Reinsurance transactions, therefore, can grossly distort results.

To account for reinsurance activity, Bunner suggests that a ratio of 4 to 1 for gross premiums written to surplus allows for up to 25 percent reinsurance premium credit to achieve the 3 to 1 National Association of Insurance Commissioner ratio benchmark. If a company has to reinsure more than 25 percent of its direct premium business, Bunner suggests an agent ask why, and then verify the financial security of the applicable reinsurance company or companies. "I would question closely", says Bunner, "companies that are in effect using reinsurance to broker significant amounts of direct business (25 percent or more of direct premiums) and, particularly if the direct business is being channeled to the non-admitted market.

Two Year Operating Ratio: The two year operating ratio is an IRIS test that is basically an expansion of the combined loss and expense ratio where the ratio of the investment income to premiums earned is deducted from the combined ratio. Using financial figures for two years helps to level possible aberrations. Bunner says, "We traditionally have expected the two year operating ratio to be a result of 100 or less. A result in excess of 100 suggests that the company is not achieving an underwriting profit, but relying on investment income to offset underwriting losses and to achieve a reasonable return on equity".

A quick calculation that can be done on a quarterly basis to achieve the same conclusion is to compare net income (exclusive of realized gains and losses) to prior years surplus. A result of less than 10 percent generally may be indicative of potential problems. A return on statutory equity of 10 percent or less hardly justifies the opportunity cost of the company's investment in statutory surplus. If the stockholder(s) are not willing to insist on an adequate return on equity, you may want to make some further inquiries.

For both these tests, realized investment gains and losses should be excluded from investment income. This is a modification of the IRIS test which Bunner believes is appropriate because such gains and losses are non-recurring transactions and largely discretionary. From time to time, companies have been known to selectively sell appreciated assets to improve the appearance of operating results.

Surplus to Admitted Assets: Surplus to admitted assets generally exceed 25 percent for most insurance companies. A ratio of less than 20 percent for an individual insurance company should be considered questionable. According to Bunner, "surplus provides a cushion for absorbing potential above-average losses". As discussed in the next section, deficiency in loss reserves usually carries over into higher multiples when related to surplus.

If the company under evaluation is a member of a holding company system and fails this surplus ratio, Bunner suggests an agent should not be dissuaded by any arguments from management that the company's surplus is reinforced by the adequacy of the surplus of the parent or affiliated

companies. Bunner states, "I strongly believe that every company granted a charter should be financially independent and its economic viability should not be dependent on other related entities."

Reserves to Surplus: The ratio of loss and loss expense reserves to surplus is not an IRIS test. However, Bunner thinks that ratio deserves more consideration by the National Association of Insurance Commissioners because of the extreme leveraging that is now more common in the insurance industry. It would be preferable if this ratio could also be calculated on a gross basis (before reinsurance) rather than on a net basis (after reinsurance). Bunner believes that a net loss and loss expenses reserves to surplus should not exceed 3 to 1.

The Acid Test: This is Bunner's own formula for quickly evaluating company liquidity or as certain what he refers to as "hard surplus". Obviously, the formula can be refilled but it does adjust for some of the weaknesses of statutory accounting. For this test, subtract from surplus the home office building(s), computer equipment, and any non-insurance receivables and other non-insurance assets that are reported as admitted assets by the company.

This adjustment separates from surplus that part of surplus which is basically applicable to the operating assets of the company. From this adjusted surplus amount subtract any affiliated investments and advances; unrealized losses on investments in bonds and preferred stocks; and any contribution certificates, surplus notes and subordinated debentures; and add back the surplus appropriation for accumulated excess Schedule p reserves.

The adjustment for affiliated investments and advances is to remove from surplus the effect of any pyramiding of assets which in extreme situations often contributes to insurer solvency. Unrealized losses on bonds and preferred stocks are typically disclosed in report supplements included with a company's annual statement on file at state insurance departments. Bunner believes that all investments held by an insurer should be reported at their current value.

"The current accounting model," he says, "using amortized costs for fixed yield securities is too forgiving to company management. Statutory accounting obscures the effect of lost investment opportunities and encourages investment decisions (particularly investment holds or sell decisions) to be driving by accounting rather than economic conditions. Once all the adjustments above have been made, a surplus of less than zero. He suggests that the company may have liquidity -problem or be over leveraged.

In closing, Bunner suggests that the failure of anyone or more than one of these tests is not necessarily indicative of a company financial problem. Further, these tests do not adequately consider some complex financial issues associated with reinsurance, security of letters of credits, off balance sheet commitments and issues related to specialty companies writing insurance products as earthquake, professional malpractice, financial guarantee bonds and so forth. However, prolonged failure of any of these tests might suggest that company management is choosing to operate outside the boundaries of sound financial guidelines and should be suspect.

Non-Technical Analysis

Reinsurance: Reinsurance is an effective tool for spreading risk and expanding capacity in the insurance marketplace. The strength of the guarantees backing the primary policy, however, is only as strong as the financial strength of the re-insurer. Abuses have occurred where the levels of

reinsurance have been too high, the quality poor and the controls nonexistent. Industry analysts suggest that the total amount of reinsurance should not exceed 0.5 to 1.3 times a company's surplus.

Agents should also be concerned about foreign reinsurance since the U.S. regulation and control is difficult. See how much of the foreign reinsurer's assets are held in the United States. Ask if the reinsurer has directly guaranteed the ceding company or using bank letters of credit for this purpose. These credit letters have not been effective guarantees in the past.

Under terms of the ceding contracts, can the reinsurance be "retro-ceded" or assigned by another reinsurance company: it is possible to have layers of reinsurance which could create difficult legal maneuvering during a liquidation. Does the ceding contract have a "cut-through" clause which allows the reinsurer to pay deficient policyowners or insureds direct, rather than to the liquidator? Is the insurer writing a significant amount of new business that may require costly amounts of first year reinsurance?

First-Year Reinsurance: The first year that an insurance policy goes on the "books", the insurance company suffers a loss. This is attributed to laws related to the accounting valuation of the policy and the high costs or expenses paid in the first year (commissions, etc). A loss to an insurer, is also reduces a company's surplus. A strain on surplus can create all kinds of problems with regulators and lenders, so insurance companies go to great lengths to shore up their surplus from the losses of first year policies.

This may be accomplished by raising additional capital or through some form of financing. More often than not, however, an insurance company will simply call up the local reinsurance company and obtain surplus relief reinsurance. Once in place, surplus reinsurance provides the ceding company (the insurer who uses the reinsurance funds) with assets or reserve credits which improve the insurers earnings and surplus position. The major difference between using reinsurance to cover first year losses and a loan is how the transaction is reported.

When an insurer obtains a loan, the accountant must record a liability. Reinsurance for surplus relief, however, is not considered a liability under statutory accounting because the repayment is tied to future profits of the policy or policies being reinsured. Collateral for the reinsurance, in essence, is future profits. Thus, reinsurers run substantial risks when the ceding company cannot pay.

The fee or interest for providing the reinsurance is typically from 1 percent to 5 percent of the amount provided. Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners for implementation starting in 1994.

The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows: If the reinsurance agreement is entered into for the principal purpose of providing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged."

Restructured Loans: What percent of an insurer's nonperforming or underperforming real estate projects have been "restructured"(sold and self-financed to a new owner at favorable terms to eliminate a "drag" on surplus)

Size of Company: Statistically, fewer insurance failures have hit companies with assets greater than \$50 million. It is thought that larger companies have more diverse product lines, big sales forces, and better management talent.

Lines of Business: An agent may not have many choices over the company he writes, e.g., worker's comp coverage can only be secured with a carrier willing to write worker's comp. It has been suggested, however, that agents may consider evaluating multi-line companies to determine if one of the lines is weak enough to "down-drag" a profitable line.

An example could be a life company that also writes health insurance as a direct line or business or by affiliation. If health carriers become threatened under a new national health care proposal, it could spell trouble for an insurer's health line which can affect all lines of business written. Of course, this is not to say that a multi-line carrier cannot be profitable and solvent.

State Admitted: Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries. Some states will also divulge the rank of an insurer by the number of complaints per premium volume.

Mergers: Insurance ratings are sacred territory. A rating drop against Mutual Benefit Life triggered a run on that insurer which caused its conservatorship. This news and the overall crisis of confidence surrounding the insurance industry has prompted insurers to consider many options to shore up these ratings. One option is the merger. The combining of companies can be critical to retaining policyholders, attracting new customers and maintaining investment capital sources. Some experts believe that consolidations in the insurance industry will become more commonplace in the future. One source estimated that the current number of life insurance companies—estimated at 2,000—will merge down to an eventual 200 insurers sometime in the future.

Parent & Holding Company Affiliation: Who or what kind of company owns the insurer that is considered. Is the parent sufficiently solvent that it will not recruit or siphon funds from the insurer? In a like manner, does the insurer own an affiliate that may likely need capital infusion from the insurer? Has the agent's insurer recently created an affiliate and are the assets in this affiliate some of the non-performing or underperforming investments of the original insurer?

Is a merger in the offing that might mingle your clients A-rated company with a larger B+ company? In what partnerships or joint ventures does the insurer participate? Do these entities own problem real estate properties of the original insurer? Has the insurer invested in other insurance companies and have those companies, in turn, invested back in the original insurer or one of its affiliates?

Name recognition can go a long way in giving a client a high level of comfort. But abuses do occur. For example, Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "non-insurance" parent. Further, not all abuses have been on the side Of the parent Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes including sale and leaseback arrangements and the securitization of future revenues.

GAAP Bending (Generally Accepted Accounting Principles): Even before the National Association of Insurance Commissioners' risk based capital proposal, insurance companies were feeling regulatory heat for a fairly common practice involving underperforming and nonperforming real

estate. In the past, insurance companies have simply carried the value of their real estate at its historical cost.

Yet, it makes little sense to use this approach when that property is not economically viable and is worthless. This is especially true in the early 1950's where the fair market value of commercial property have decline rapidly and perhaps below historical cost. However, showing lower valuations would mean that insurers might develop capital deficiencies or incur substantial write downs.

Either situation is hard to apply. Now, new GAAP (Generally Accepted Accounting Principles) rules are being used by auditors which require foreclosed property or underperforming real estate to be valued at its current fair market value. Insurers must decide whether to continue holding an asset until the economy rebounds or risk further deterioration. Further, now that risk based capital is on their doorstep, holding nonperforming real estate may require companies to set aside additional reserves. In the past, if regulators started complaining, insurers would increase their capital, either from a parent company or through security offerings. While this would aid the insurer's liquidity, the original asset would remain on the books, perhaps at a deep discount.

Asset Spin-Off's: Insurer balance sheets can easily get out of line if they hold underperforming or nonperforming real estate. As mentioned above, new GAAP write down rules would require a valuation of this real estate at its current fair market value, which may be extremely depressed. To help "clean-up" their balance sheets and possibly avoid strict risk based capital requirements, some insurers transfer or "spin off the foreclosed or underperforming asset to a new entity which they create.

This entity sells bonds or stock to the general public to buy the problem asset(s) from the insurer. Since this is considered a sale, the asset gets off the books. The need to set aside reserves and meet GAAP rules is eased. And, company ratings are maintained. In all fairness to insurers, what appears to be a deception is often a sound business strategy to "hold" an asset that is not performing today but is expected to rebound when the economy improves.

So long as this can be accomplished and not hamper current operations, the insurer may be making a smart move since significant appreciation in the asset down the road could later improve the company's balance sheet by leaps and bounds. Also, "spin-offs" are not without their risks. There is the cash drain of starting a new entity, the deep discount of the sale and the possibility of a taxable event.

Collateralized Mortgage Obligations & Derivatives: In the past, when insurance companies wanted higher investment yields they turned to real estate and non-investment grade bonds. New risk based capital rules, however, make these types of investments difficult to "book". Insurers, however, have found ways to still participate in the yield of these investments without owning the actual product: collateralized mortgage and derivatives.

In simplest terms, collateralized mortgage obligations and derivative are like stock certificates backed by mortgages or bonds. The "slant", however, is that they are owned by a trust and then sliced into pieces of various maturities consisting of principal and interest payments. They are also further divided into issue classes called "tranches".

The first principal payment, for example, would go to Tranch 1; and so on. Tranch 2 might be "interest only" strips. Investors will jockey for particular tranches based on their rate of interest, their individual

requirements and their outlook on where interest rates are going. Investments in the junior tranches offer significant yields, yet come with the risk of prepayment. Senior tranches generally minimize market risks since cash flows are more predictable. Suffice to say, CMO's and derivatives are highly sophisticated, higher risk investments that require sophisticated monitoring and significant hedging capability.

Tax Angles: Regulators and accounting practices appear to be getting stiffer for insurance companies. One thing the industry can still count on is certain tax advantages. In essence, losses from insurance operations can be used to lower taxes elsewhere (such as capital gains from the sale of bonds or real estate). Multiline companies, can use losses from property and casualty claims to offset profits from health and life insurance divisions.

Surprisingly, companies can sometime take a percentage of their losses as a "tax credit" and write it up as an asset on the theory that the tax credit will be worth something to them in a profitable year. This practice is acceptable as long as the company can show beyond all doubt that it will be able to use the credit sometime in the future. Critics, feel that the tax credits are actually "paper profits" which can hardly be used to pay claims.

In periods where insurers are posting major losses-such as the mid 1980's and early 1990's--tax credits such as these may account for up to 70 percent of a firms operating income. How much of an insurer's operating income consists of tax credits generated from claim losses or guaranty fund? How much of an insurer's operating income comes from large capital gains earned from the "bulk sale" of longstanding bonds or real estate?

Restructuring Loans & Partnership Deals: The last thing an insurer wants from its books is foreclosed or underperforming real estate. New risked based capital and GAAP accounting standards deal harshly with this type of asset. This is exactly the type of asset, however, that many insurers are "knee-deep" in handling, especially on the heels of big real estate purchases in the late 1980's with money raised from guaranteed investment contracts (GIC's).

A way to alleviate the underperforming properties is to convert them to new loans - essentially refinance them for the owners at new, easier to handle payments - or restructure the existing loans by temporarily dropping the payment. It is also interesting to note that many insurance companies own problem properties and assets that regulators do not see because they are owned through a partnership between the insurer and a joint venture entity.

Liability Adjustments: Reducing liabilities is always desirable since surplus will be enhanced. Some companies make small adjustments to their liabilities to make them appear smaller. One such adjustment can be accomplished by deducting the surrender charges policyholders would pay if they cashed their policies in early.

Companies have been known to take this deduction knowing that not all policyholders will require early withdrawals or full surrenders of their policies. Some insurance regulators still allow this accounting method.

Cash/Stock Swaps: When things get tight, some insurance companies invest in each other or among their subsidiaries using a system of complicated cash and stock swaps.

Selling Loss Reserves: Under pressure to improve earnings, insurers have used the somewhat questionable technique of "selling loss reserves". How does an insurer sell losses? Generally, it involves paying another insurer now for its promise to pay certain claims in the future.

A few years back, for example, a carrier passed the liability for an estimated \$80 million of unpaid medical malpractice insurance claims to another carrier in return for an agreement to eventually pay those claims. The buying carrier received a steep discount on the claims for a profit of approximately \$22 million. The selling carrier relieved itself of \$80 million in liability. Reinsurers are also big buyers of loss reserves. Critics say it's an accounting gimmick. Industry spokespersons claim it is merely a method of transferring risk.

Insurer Insolvency

When a state determines that an insurer is in trouble, the insurance commissioner usually files an application to the court. The court petitions the insurance company to show cause why the company should not be placed in rehabilitation or liquidation. Once a company is placed under supervision, an injunction is issued to restrain the insurer, its officers, agents and others from any disposition of property without court approval.

Liquidation is the more severe condition where the insurance commissioner must take title to the insurer's assets and use them to pay creditors and policy owners. Rehabilitation, on the other hand, allows for a restructuring of the insurer under the guidance of the commissioner. Unless the condition is extremely severe, companies are usually started in rehabilitation. If it is later determined that a restructuring will still not revive the insurer, a liquidation is ordered. If an insurer is liquidated, all policy owners and other potential claimants must be informed and permitted to file a proof of claim with the insolvent estate.

These claims will then be evaluated and a value established. Recent failures have demonstrated that claim values can be less than the amount due the policy holder. Under these conditions, a policy owner can file an appeal and seek a court decision before the actual liquidation of the company occurs. In order to protect the overall insurer estate, there are time limitations for filing these appeals. Once all appropriate values are determined, the assets of the insurer will be distributed under a statutory procedure. This process requires that certain priority lien holders be paid in full, while others may divide what is left.

The typical liquidation order of priority is as follows:

1. Liquidation expenses and costs
2. Unpaid wages of employees of the insurer
3. Taxes
4. Policy holders, insured's and guaranty funds
5. Reinsurers and all other claims

If a reinsurer indemnifies a liquidating company, it is only required to pay to the liquidator the actual loss it indemnifies. In other words, the reinsurer can only be called upon to pay deficiencies up to the limit it has agreed, once the ceding company, the liquidating insurer, has made all possible payments. This provision, which appears in most reinsurance contracts, is called an insolvency clause.

The disadvantage of an insolvency clause is that policy owners, guaranty funds and other third-party claimants have no additional claim against reinsurance proceeds. An exception to this rule is where a cut through clause exists. A cut through endorsement would require a reinsurer to pay a loss or specified portion of a loss directly to the policy owner or insureds when an insolvency or another specific event occurs. General creditors and other third party claimants could be excluded under a cut through endorsement.

The Need for a Safety Net

In any competitive environment, even one as intensively regulated as insurance, insolvencies will occur. The proper role of insurance regulation is to avoid financial failure if possible, detect it as soon as possible when it cannot be prevented, and act promptly to contain its size and impact once the insolvency is known. The vast majority of insurers failed because they priced their product too cheaply. They neglected to underwrite adequately by identifying the nature and extent of the insured risk.

In almost all these cases, the signals were disproportionate increases in premiums written; entry into new and exotic lines of business; risky investments; precipitous drops in surplus; reinsurance to temporarily bolster surplus; overly generous dividends to parent companies; and low claim reserves. A Best's Insolvency Study confirms this conclusion.

Of all property/casualty insolvencies since 1969, 28% were caused by inadequate pricing, which resulted in inadequate loss reserves; 21% by rapid growth; 10% by alleged fraud; 10% by overstated assets; 9% by significant change in business; 7% by reinsurance failure; 6% by catastrophic losses; and 9% by "miscellaneous".

Some believe that inadequate pricing and deficient loss reserves, rapid growth, overstated assets, and significant change in business should have been detected through regular examinations, market conduct exams, holding company reports, annual statements and CPA audited annual reports of non-insurers, as well as by just listening to street talk. It is true that a few insurers were known by general industry discussion to be in trouble long before regulators took action.

Their domestic commissioners can prevent by exercise of the existing regulatory authority by the ceding insurer's domestic commissioners as to the granting or denial of credit for unauthorized reinsurance and by the regulation of the solvency of licensed reinsurers reinsurance failure as a cause of insolvency. Moreover, "reinsurance failure" as it impacted on some ceding insurers can more appropriately be characterized as "poor management" by the ceding insurer because, as Best's stated, they "purchased the least expensive reinsurance protection without sufficient regard to the financial strength of the reinsurer."

Many insolvencies attributed to "reinsurance failure" are almost always the result of other causes, with reinsurance only becoming a factor after the ceding insurer has been declared insolvent, when the reinsurer disclaims its coverage, alleging fraud.

The biggest states with larger department funding were those with the most insurer failures. Best also confirms this failure of the regulatory giants. Of the 372 property-casualty insurance insolvencies between 1969 and 1990, 187, or 50%, occurred in six states. These states, that domiciled only 34% of the insurers during the period, were Texas (47 insolvencies); California (35 insolvencies);

Pennsylvania (35 insolvencies); New York (30 insolvencies); Illinois (22 insolvencies); and Florida (18 insolvencies).

Of these six states, four, California, New York, Texas and Florida, accounted for 48% of the \$429 million budgeted for all 50 state insurance departments (plus those of the District of Columbia and Puerto Rico), and the other two highest insolvency states, Illinois and Pennsylvania, with another 5.6%, were in the top 9 states with the highest regulatory budgets. It is unlikely that more money to these six states would have avoided any insolvencies.

Why do states so rich in funding and expertise permit so many large insolvencies to occur? Why don't they catch them sooner? One school of thought blames the political nature of insurance regulation and the very existence of guaranty funds. As insurance has become a more public factor in our economy, insurance regulators have found themselves in an increasingly political arena. They have permitted or been forced to allow their focus to shift from the primary role of the regulator to what has become the more visible issue of pricing.

Rate and policy form approval, particularly for commercial insurance where the buyer neither needs nor wants this layer of "protection", drains essential regulatory resources that could better be directed to the solvency of insurers. Examinations of insurers that focus on trivia as much as essentials and that take up to three or more years to complete, being outdated by the time they are released, no longer perform the investigatory and preventive role that used to spot trouble before it became fatal. Like everyone, insurance commissioners do not like to admit failure, and many commissioners and their staff view the insolvency of a domiciled insurer as a personal and institutional failure.

Regulators welcome promises of cash infusion, assertions of improved payout patterns, claims of better quality of new business and investments, and the assertion that "things can't get any worse," anything to avoid or delay the admission that, despite their best efforts, a failure occurred. Unfortunately, in too many cases these promises are unrealistic and are never fulfilled, and, during the period of regulatory indulgence, the insurer's Financial condition rapidly deteriorates, new policy holders pay for coverage they will never receive, and, as a result, other insurers and taxpayers end up paying more to clean up the default. Although the insolvency most likely was predetermined years earlier when bad business was written below cost or unrealized investments were made, the situation worsens as new business is written at even less adequate prices in desperation to maintain liquidity.

State Guaranty Funds

The purpose of the state guaranty associations is to fully guaranty the reasonable expectations of the vast majority of individual policy and group insurance certificate holders. It is important to note that these associations do not exist to underwrite any and all promises, no matter how large or reckless. In essence, state guaranty associations have limitations.

Guaranty associations are created by state law "to protect policy owners, insureds, beneficiaries, annuitants, payees and assignees against losses, both in terms of paying claims and continuing coverage, which might otherwise occur due to an impairment or insolvency of an insurer." When an insurer becomes insolvent, it frequently exits the market with liabilities in excess of its assets.

To date, state legislators have used guaranty funds to shift most of the burden of the shortfall from the policy holders of the insolvent company back to insurers. Absent guaranty fund protection, the policy holders of the insolvent insurer would be forced to absorb the complete loss produced by the

insolvent insurer. Guaranty funds provide policy holders and beneficiaries with an entity ready to absorb most of the losses left by the insolvent insurer.

Guaranty funds are able to provide protection to policy holders by assessing surviving insurers for amounts necessary to pay the claims of the insolvent insurer. Essentially, these funds shift the burden of the shortfall from policy holders to surviving insurers. Managers of the surviving insurers must then allocate the assessment.

Groups that could be called upon to absorb the assessment include: equity holders, policy holders, employees, and taxpayers. Most states use premium tax credits to shift the shortfall to taxpayers. The assessment paid by insurers can be viewed as an interest free loan to the state by way of the guaranty fund. The loan is partially repaid in the form of tax credits and deductions. Federal taxpayers also receive part of the burden as assessed insurers deduct their assessments from taxable income.

The Liquidation Process: The liquidation process can be extremely involved and lengthy. This is the reason that guaranty funds were established. They are an advance payment system to pay off individuals and groups who would be devastated by the liquidation process. A claim against a state guaranty fund is typically limited to residents of that state.

Payments are limited to certain amounts, depending on the type of insurance purchased. Once a claim has been paid, the guaranty association becomes subrogated to the claimant's rights to further payments. Thus, a policy holder who collected from a state fund forfeits his claim rights against the insolvent insurance company. The guaranty associations are non-profit legal entities whose members comprise all insurance companies licensed to write insurance or annuities in the state. Each association is governed by a board of directors approved by the state's insurance commissioner.

Exclusions: In general, guaranty acts exclude from coverage policies issued by entities that are not regulated under the standards applicable to legal reserve carriers. Insurance exchanges, assessment companies, fraternal, HMOs and, in many cases, Blue Cross and Blue Shield are commonly excluded.

The guaranty laws also commonly exclude from coverage policies or portions of policies under which the risk is borne by the policyholder or which are not guaranteed by the insurer. Variable accounts in some life policies or annuity contracts are examples. Significant variation does exist in the treatment of unallocated funding obligations (UFOs), including GICs, which are commonly purchased as pension plan assets on professional, sophisticated advice by pension plan trustees.

Limits of Protection: Most guaranty associations limit their protection to policyholders who are residents of their own state. (It does not matter where the policyowner's beneficiaries live.) The trend toward adopting such a residents-only provision follows a major amendment to NAIC's model guaranty act adopted in 1985.

Arizona, Virginia, West Virginia, Nevada, North Carolina and Oregon very recently amended their life-health guaranty laws to cover only their own residents. However, if the insolvent insurer's domiciliary state follows the NAIC model, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty act and the impaired company was not licensed there and the policyholder is not eligible for coverage there.

An example of such a situation would be a New York resident who owns a policy of the Executive Life Insurance Company, which is domiciled (chartered) in California. Since New York has a life-health guaranty association but the company was not licensed to do business there, New York residents will be covered by the California Life Insurance Guaranty Association. However, residents of a jurisdiction such as the District of Columbia which does not have a life-health insurance guaranty association would have no guaranty association protection, even though Executive Life was licensed there.

Other states, like Alabama, still follow an older model act and guaranty benefits of impaired or insolvent insurers domiciled in their own state, no matter where the policyholders live, and also cover their own residents who are policyholders of licensed companies domiciled in other states, unless coverage is provided by the state of domicile.

Dollar Limits: Typical payouts to policyholders who are victims of failed or financially strapped insurance companies might read as follows:

Life and Health Guaranty Funds

- Maximum death benefit \$300,000
- Maximum cash value covered \$100,000
- Maximum Annuities \$100,000
- Maximum Health and Disability \$100,000
- Maximum Aggregate Per Person \$300,000

Property/Casualty Guaranty Funds

- Maximum Claim \$300,000 - \$500,000

Individuals who have several policies may have additional limits. For example, a person who owned a term life insurance for \$500,000, a whole life policy with cash values of \$150,000 and a single premium annuity with an accumulated value of \$200,000, will collect only \$300,000, the maximum aggregate limit per person regardless of how many policies.

The fact that these policies may be spread among three different insurers does not make any difference. There would still be a \$300,000 maximum in most states. The same is true for property/casualty claims. Regardless of the number of policies or how they are distributed among different insurance companies, the maximum claim that can be paid by a state guaranty fund is fixed at between \$300,000 and \$500,000 per individual.

It is also interesting to note that limits of State Guaranty Funds are strictly limited to the basic coverage of the policy.

Triggers: Generally, state guaranty associations provide coverage is triggered when the company has been declared financially impaired or has been ruled to be insolvent by a court of law. However, there are some situations preceding such a judicial action when many associations may take measures to cover the impaired insurer's policyholder obligations, particularly for health benefits, death benefits, and immediate annuity payments. However, since the primary purpose of the guaranty associations is to protect policyholders, and not to bail out impaired or insolvent insurers, most associations are reluctant to provide coverage before an order of liquidation, unless it is clearly demonstrated that to do so in a particular case will be less costly over time.

Coverage Options: Guaranty associations may provide coverage directly, or through outside administration or other insurance companies. In many cases, the guaranty association will continue coverage for the full policy period. It may do this directly or it may transfer the policy to another insurer or administrator. In multi-state insolvencies, most guaranty associations work through NOLGHA to secure an assumption reinsurance agreement with another insurer or a claims servicing agreement with a third party administrator on a multi-state basis. If the impaired or insolvent insurer is licensed in more than one state, as most are, NOLHGA's affected member associations try to work closely through our Disposition Committee with domestic receivers to protect policyholders and insure early and equitable access of guaranty associations to the insolvent company's assets. On behalf of its participating member guaranty associations, NOLHGA's Disposition Committee expedites reinsurance assumptions, claims processing and audits.

Reinsurance

Reinsurance and insurer safety are closely related since reinsurance plays a vital role in helping all types of insurance companies meet their everyday commitments. Unfortunately, the reinsurance market has taken some heavy blows in recent years, including some direct links to primary insurer failures. Record losses and mismanagement in have caused many to leave or fold making reinsurance harder to come by and more expensive when you can.

The shakeout is a huge wake-up call for the industry, including agents, who need to be more alert to their own company's reinsurance arrangements in the future. Some primary insurance companies who also sell reinsurance have suffered the hazards of double exposure by having to pay claims from both their primary and reinsurance divisions. It is also the contention of some industry groups that abuse of the reinsurance system, including some questionable reinsurance schemes by depressed insurers and foreign reinsurers, has been a key factor in almost every insolvency.

Reinsurance Defined: Reinsurance is often described as the insurance of insurance companies because it provides reimbursement for the insurer's losses under policies covered by the reinsurance contract. Insurance placed with the reinsurer is called the ceded amount, and the company that receives the benefit of the insurance is called the ceding insurer. Insurance purchased by reinsurers to cover their own losses is called retrocession.

The process of reinsurance involves a transaction whereby the reinsurer, for a premium, agrees to indemnify the ceding insurer or reinsured against all or part of its losses under policies written. It is a transaction which does not involve the policy holder who looks only to his insurer for defense and indemnity against loss. Reinsurance is purchased by a primary or an excess ceding insurer for its own benefit so that it can spread its risks and limit its own liability from large or catastrophic losses. Reinsurance is often confused with excess of surplus line insurance. However, the two are totally unrelated.

Excess and surplus line insurers are primary companies providing direct coverage to insurance consumers. Their function is to supplement the standard admitted insurance markets. Excess and surplus line insurers are, in turn, large purchasers of reinsurance.

Sources & Reasons for Reinsurance: Reinsurance can be obtained through three distinct sources: professional reinsurers, reinsurance departments of primary insurance companies and unauthorized

alien reinsurers. The insurance premium charged policy holders by insurers includes the cost of reinsuring the risk. In other words, there is no added charge to the policy holder.

The primary company calculates the premium on a gross basis and all reinsurance expenses are incorporated in the premium. The insurer has the responsibility to evaluate the risk in its totality and to price the risk according to the potential loss exposures. The distribution of the reinsurance premium between the insurer and the reinsurer is a separate transaction which does not involve the policy holder. There are many reasons primary insurers purchase reinsurance.

The two most important are to limit their liabilities and to increase their capacity. An insurance company may wish to cap its exposure to losses in one or a combination of three ways: a per risk limitation, a catastrophic loss limitation or an aggregate of loss limitation. Prudent insurance management and certain insurance regulations demand that a company place a limitation commensurate with that company's surplus or equity on any one potential loss exposure, even though the company may provide coverage under an insurance policy in amounts considerably in excess of this prudent "retention". This is where reinsurance comes in.

The individual company's retention may be anywhere from a few thousand dollars to several hundred thousand or even in the million dollar range. Whatever the loss exposure may be above the retention, up to the policy limits of the reinsurance contract, if any, becomes the responsibility of the reinsurer. Most companies also seek to protect themselves from a disastrous accumulation of losses arising from a single event.

No one single loss payment arising from the event might be beyond the company's individual risk retention level, but the accumulation of all the losses arising from the incident might be excessive for that company. Generally speaking, an insurer estimates the probable maximum loss to which it may be exposed, based on its business concentration in any particular geographical area, compares that exposure to its surplus and purchases reinsurance to cover the potential losses which exceed a prudent level of catastrophic retention.

Another approach often used by companies to limit their potential liabilities attempts to cap the aggregate losses which may be sustained over a specific period either with respect to its total combined losses for the period or the combined losses for certain lines of insurance. The important reason an insurer may want to purchase aggregate loss reinsurance is to stabilize its operations from year to year. By providing a mechanism whereby companies may limit their loss exposures to levels commensurate with their surplus, reinsurance allows those companies to offer coverage limits considerably in excess of what they could provide otherwise.

This is a crucial function for small to medium size companies, allowing them to offer coverage limits which meet the needs of their policy holders. If only the larger insurers could do so, there would ensue considerably less competition and insurance capacity would be much more restricted than it is today.

Reinsurance further enhances an enlarged capacity by a variety of other approaches which are related to accounting procedures. When an insurance company issues a policy, the expenses associated with issuing the policy, such as taxes, agent commissions and administrative expenses, become a current charge on surplus, while the premium collected must be set aside as an unearned premium reserve.

The premium can only be considered as earned by the company and available to it over the life of the policy. This mismatch in accounting between premium and expenses makes good sense from a regulatory standpoint in that it allows for a more conservative accounting, commensurate with regulation for solvency. But it penalizes insurers to the extent that the more business they write, the more they must draw down on their surplus, thus reducing their capacity.

By reinsuring a part of the business written, an insurer is able to limit the impact of the mismatch since the reinsurer must reimburse its client company for its proportionate share of expenses. The reinsurer then is the one which must reduce its surplus by the expenses it absorbs from its reinsured. Similarly, when a claim is presented to an insurance company, a loss reserve must be established for the amount of anticipated claim payment. The reserve also comes from the company's surplus. However, to the extent a reinsurance recovery is anticipated on the claim and the reinsurer qualifies under state regulation, the insurer may limit its loss reserve to the extent of its own estimated "out of pocket" liability.

There are other approaches to reinsurance as a mechanism to enhance capacity. One such approach which was used perhaps to excess in the past is known as a "loss portfolio transfer". Under this transaction, the insurer "sells" a portion of its loss reserves to the reinsurer which promises to pay the claims represented by these reserves when they are finally adjusted. Assuming that the loss reserves being transferred to the reinsurer exceed the payment which the insurer makes to the reinsurer, the difference may be added to the insurer's surplus, thus, enhancing its capacity.

Reinsurers provide other services besides financial transactions aimed at limiting an insurer's exposure to losses, stabilizing an insurer's operation or enhancing its surplus to increase capacity. Many reinsurers are equipped to provide guidance to insurers in underwriting, claims reserving and handling, investments and even general management. These services are particularly important to smaller companies or to those which may wish to enter new lines of insurance.

Limitations of Reinsurance: First and foremost, reinsurance does not change the inherent nature of risk being insured. Thus, it does not make a bad risk insurable. Neither is reinsurance, nor can it be made to be, a subsidy allowing under-pricing of risks. Also, reinsurance does not make a risk exposure more predictable or desirable. While it may limit the exposure to a risk from the standpoint of the primary insurer, the total risk exposure is not altered through the presence of reinsurance. **Regulation of Reinsurance:** Regulation cannot substitute for good management practices. The placement of reinsurance is a major responsibility of insurance management. It is a responsibility which cannot be substituted by regulation. There are many public and private resources and controls available to check the security and management of reinsurance companies.

All states today require reinsurance contracts to include certain clauses which are of overriding public policy. All contracts, for example, must contain an insolvency clause which requires the reinsurer to pay all reinsurance proceeds to the liquidator, in the case of insolvency of the insurer, without diminution resulting from the insolvency.

Probably the biggest issue with regard to reinsurance regulation is the control and policing of offshore or alien reinsurers. The U.S. is one of very few countries in which alien insurers may operate either through wholly owned subsidiaries or through branches or, in fact, both. A foreign domicile adds an additional layer of insulation between U.S. regulators and the reinsurer.

A simplistic approach would be to limit the U.S. reinsurance market to U.S. domestic or licensed companies. Traditionally, however, the international reinsurance markets have been the main source of retrocession insurance. The influence of the London markets, in particular Lloyd's of London, has been substantial. While it is true that reinsurers must file financial reports and are examined like primary insurers, there are some areas, where regulation of alien reinsurers falls short:

- Regulation of reinsurance cannot be so restrictive as to preclude adequate capacity. Regulators cannot be so rigid as to completely banish the supply of reinsurance.
- The channeling of reinsurance to more secure markets seems to be defeated by U.S. tax policy. The only tax on U.S. reinsurance premiums ceded to alien companies is the U.S. excise tax, a one percent gross premium tax. U.S. reinsurers, on the other hand, pay income tax equivalent to 7.5 percent of premium. The resulting difference has placed U.S. reinsurers at a major competitive disadvantage
- The difficulties in regulating an international commodity such as insurance and reinsurance are, in part, due to the limited geographic reach of regulators, as noted in the report. However, the major difference is accounting conventions, country to country, are themselves major obstacles which would not disappear under a federal regulatory system. To establish minimum solvency standards for all companies doing business in the U.S. becomes a formidable task when these differences are taken into consideration.
- Currency fluctuation is another element which any international regulatory system must consider. Settlement payments could lose substantial value when siphoned through the "swings" of a wild currency exchange.

Underwriting

Underwriting is a critically important function and is performed each time an insurance application is taken. Its purpose is to determine if the applicant is acceptable to the insurer to determine whether or not the insurer will issue a policy. Underwriting is based on a variety of criteria, established by each insurer and regulated by state and federal law. Each underwriting decision involves balancing the insurer's desire to earn premium with the insurer's ability to cover claims and remain in compliance with regulatory financial requirements while making a profit.

What is Underwriting?

Underwriting is the function of evaluating the subject of insurance, whether a person, property, profession, business, or other entity, and determining whether to insure it. The underwriter must apply company standards to each applicant, and, based on these standards, ascertain whether the application represents an acceptable risk.

Underwriting is the foundation of the insurance transaction process. The term underwriter arose out of marine insurance. In the 17th Century, merchants who were willing to take on a portion of the risk for voyages would list the amount of the voyage they were willing to insure and sign their names underneath a contract that detailed the terms of the risk.

These merchants became known as underwriters because they wrote their names under the contract terms. Since that time, the insurance business has evolved and policies are no longer underwritten by individuals who insure risks, but the term underwriter continues to be applied to those who review and select risks to insure.

Factors in Underwriting

The factors used during the underwriting process varies somewhat, based upon the type of insurance being underwritten. If people are being insured, such as under life, health and disability insurance, key factors used in the underwriting process may include:

- Age
- Sex
- Health and health history
- Occupation and occupation history
- Financial condition
- Personal habits such as smoking or drinking alcohol
- Size of the policy
- Current insurance in force

If property is insured, as in homeowners, automobile, and commercial property insurance, underwriters may review factors such as:

- Type of the property
- Value of the property
- Condition of the property
- Construction materials used in the property
- Potential hazards surrounding or within the property
- Age of the property
- Use of the property
- Security measures and other loss control measures associated with the property
- Upkeep of the property
- Location of the property
- Current insurance in force on the property
- Prior losses associated with the property

If a business or business operations are being underwritten under insurance such as general liability and professional liability insurance, factors that underwriters will weigh include:

- Type of business
- Size of business
- Financial condition of the business
- Financial condition of owners
- Business cycles affecting the business
- Liability exposures
- Experience of key employees and owners
- Past losses experienced by the business

Functions of Underwriting

Underwriting involves examining application forms, supporting documents such as appraisals or bills that verify the value of property, or medical reports that verify the health condition of an individual,

looking at insurance maps that provide information relevant to the statistical possibility of certain types of loss, reviewing statistical data applicable to the risk to be insured, reviewing company records regarding the application and evaluating site inspection reports.

Upon a thorough examination of all the data, underwriters then assign rates to the application, or decline to issue a policy if it does not meet underwriting standards. During the entire process, the underwriting department frequently communicates with agents, inspectors, adjusters and other field personnel.

Types of Underwriters

An insurance company may issue policies for many different types of insurance. However, most underwriters perform their responsibilities as specialists. An underwriter may underwrite just property policies, just casualty policies, just personal property policies, just professional liability policies, and so on.

Property and Casualty Underwriters

Within the property and casualty field, underwriters often specialize in a particular type of property or casualty coverage. Within this field there may be fire underwriters, homeowners underwriters, automobile insurance underwriters, inland marine underwriters, commercial property underwriters, personal property underwriters, commercial general liability underwriters, professional liability underwriters and Workers Compensation underwriters, for example.

These underwriters, whether they perform underwriting tasks for one line of insurance or for many lines, must understand the risks involved with each line of insurance for which they underwrite and the available and practical methods of dealing with these risks. They must also be able to gather and understand the various resources used to evaluate each application and determine whether the applicant meets company underwriting standards.

Such resources may include site inspection reports, business or personal financial statements and reports, and if a business is being insured, statistical reports generated by the industry in which the business falls, as well as statistical reports from the property and casualty insurance industry that are applicable to the risk.

Personal Line and Commercial Lines

A further distinction among property and casualty underwriters is whether they underwrite personal lines or commercial lines. Although both individuals and businesses need property and liability coverage, the insurance needs of an individual are very different from the needs of a business. In addition, there are many, many types of businesses and therefore many different sorts of risks associated with these varying business types. Therefore, within the commercial lines area, there may be many specialized underwriting functions.

If an underwriter works with commercial lines applicants, the underwriter is generally familiar with risk management principles and methods as they apply to the type of business being insured. Such underwriters also are knowledgeable regarding the type and scope of risks associated with various business occupancies. They understand that the risks related to running a supermarket are different from those that exist when operating a manufacturing plant.

Depending on the insurer, a commercial property and casualty underwriter may even specialize in underwriting specific types of businesses. For example, if an insurer markets to those needing boilers and machinery insurance and also to those with extensive data processing facilities, one set of underwriters may work with the boilers and machinery applicants and another set work with those with data processing protection needs.

If a property and casualty underwriter works with personal lines applicants, the underwriter will have a deep understanding of the specific risks facing individuals, such as homeowners or drivers. A homeowners insurance underwriter will understand differences in home construction materials, the safety impact of various security systems, and other factors that determine the rates and insurability of a homeowners applicant. A personal automobile insurance underwriter will be an expert in understanding the various safety features in all makes of cars, what types of drivers are statistically found to be safe drivers, and so on.

An underwriter working with highly valuable personal property owned by an individual will be familiar with appraisal reports and appropriate security measures that should be taken to protect the property.

Life and Health Underwriters

Another area of specialty for underwriters is life and health insurance. A life and health insurance underwriter is familiar with things such as the impact of medical history and other health issues on insurability. The health or life underwriter is able to read and understand medical reports such as the attending physician statement and data gathered from the Medical Information Bureau.

Due to the extensive regulatory environment surrounding health insurance, health insurance underwriters are also very familiar with state and federal regulations regarding health coverage.

Liability Underwriters

Liability insurance underwriters must be familiar with the liability risks found inherently in commercial businesses, professionals or individuals. They must also be able to evaluate past losses, judgments and settlements in terms of the likelihood of reoccurrence in order to determine relative future risk. They must also be familiar with current trends in court judgments and with liability laws in order to properly evaluate high-risk applicants.

Group Underwriters

Many types of insurance are written on a group basis, and health insurance is often written in this manner. Group insurance is handled somewhat differently than individual policies for underwriting purposes. Generally in life and health insurance group programs, a rate is established that applies to the entire group to be insured.

This rate is established by analyzing the characteristics of the group as a whole, as well as individuals within the group. This rate is generally reviewed and revised on an annual basis. Under some types of group underwriting, individual rates are assigned to individuals within the group, but a discounted rate is applied because the individual is part of the group, so the insurer's marketing costs are reduced on a per coverage basis. A group offering automobile coverage to its members may have rates assigned in this way. Some forms of group insurance, especially when offered as part of an employer's benefit package, are subject to special federal and state regulations. Because group

underwriting differs in operations and regulation from individual underwriting, an insurer may use specialized underwriters for group insurance.

Underwriting Decisions

When evaluating applicants, underwriters determine whether insurance on the applicant will be:

- Rejected
- Issued on a substandard basis
- Issued on a standard basis
- Issued on a preferred basis

Rejecting Applicants

Insurers reject applications for insurance when they find that the applicant represents a risk that fails outside of the underwriting standards established by the insurance company. These underwriting standards take into consideration many Hems, such as regulations that require the insurer to establish adequate rates, laws that mandate that certain factors cannot be used to reject an application, insurance principles such as insurability and indemnity, the marketplace in which the insurer sells its products and the profit the insurer hopes to make on its business.

Issuing Policies on a Substandard Basis

The decision to issue a policy on a substandard basis occurs when a risk is not deemed to be outside underwriting standards, but is considered to be of high risk within those standards. The insurer generally has three basic options when it offers a substandard policy issue to an applicant. It may:

- Issue the policy with a higher premium than would be required for a standard policy
- Issue the policy with limited benefits
- Issue the policy with certain exclusions

Higher Premium: The insurer may charge a higher premium to applicants deemed to be of higher risk than those who would be considered a standard risk as long as those higher rates fall within certain parameters. First, if the insurance policy is one that requires that rates be filed with the state in which the policy is issued, the rate must be approved by the state. Secondly, the rate may not be discriminatory. The insurer must charge every insured with the same characteristics the same rate. Thirdly, in some states higher premium may not be charged based on certain items as defined in state statutes. The insurer must of course comply with such statutes in determining whether to charge higher premium rates.

Limit Policy Benefits: Insurers may also respond to substandard applicants by offering a policy with limited policy benefits. Again, whether the insurer may limit benefits is regulated by state law. For example, under long-term care policies, some states require that policies offer a minimum home health care benefit limit as a certain ratio of the nursing home benefit limit. Therefore, a long-term care insurer could not limit the home health benefit on a policy in a manner that would not comply with such a law.

Assuming state regulations are followed, an insurer could offer lower policy limits on certain coverages to a substandard applicant, or could offer lower policy limits for all coverages to such an

applicant. Dealing with substandard applicants by limiting policy benefits is most common in commercial coverages.

Excluding Certain Provisions From Coverage: Another option an insurer may have is to offer an substandard applicant a policy that excludes coverage for certain property, insureds or operations that are deemed too high a risk for the insurer to cover. As with the other options discussed, such exclusions must be allowable under state regulations. This type of exclusion is most common in commercial property and liability coverages.

For example, an insurer may cover all the property owned by a business, except that within a building whose operations have been discontinued. Or, an insurer may offer to provide liability coverage for all business operations except for that portion that has potential pollution liability that is too high for the insurer to cover.

Issuing Policies on a Standard Basis

Underwriters base their determination that a policy should be issued on a standard basis on an analysis of the characteristics of the risk represented by the applicant. Applicants who are issued policies with standard rates fall within the normal boundaries of underwriting standards for that type of policy.

Issuing Policies on a Preferred Basis

If an application falls within the lowest risk boundaries of the underwriting standards, the policy is issued on a preferred basis. Preferred rates represent the lowest rates offered by an insurer for its coverage. Rates offered on a preferred basis must adhere to the insurance regulations applicable to them, just as rates offered on a substandard and standard basis must. Insurance regulators do not want insurers to offer rates that are so low that the insurer cannot meet its contractual obligations to pay covered claims.

Monitoring Underwriting Decisions

Once a policy is issued, underwriters continue to monitor the policy from an underwriting perspective. Such monitoring is done at policy renewal, commonly every six or twelve months, and as claims occur. Depending upon the type of policy and its provisions regarding rate increases, rates may be increased at renewal, or the insurer may make the decision not to renew the policy.

Changes in rates or the decision to non-renew are only made if allowed by policy provisions and applicable regulation. Decisions to modify rates may be based on the actual claims experience over the last policy period for a specific insured, as may occur with Workers Compensation insurance and various commercial property policies, or may be based on a rate change for an entire class of policyholders or category of insurance. State regulations often limit factors that may be used to increase rates.

For example, a state may not allow an increase in automobile rates until three claims have been paid under the policy. The decision for non-renewal, if allowed by regulation and policy terms, is typically done only if the insured has excessive claims or the insurer has decided to discontinue offering the type of insurance the policy represents. The agent also has a role in the monitoring of underwriting

decisions. The agent should meet with each client on an annual basis to review coverages and ensure all information on file with the insurer is accurate and up-to-date.

This review of coverage also serves the purpose of making sure the client's insurance needs are properly met. Contact between the agent and client outside of the annual review may also result in the receipt by the agent of updated policy information.

Updating policy information is an important part of the ongoing underwriting process. It is your duty as an agent of the insurer to promptly and accurately submit to the insurer's home office. Any changes in your client's information may affect coverage.

The Underwriting Process

Underwriting is the process of determining whether an insured is an acceptable risk, and if so, at what rate the insured will be accepted. Insurers cannot accept every applicant. An insurer has a responsibility to its current policyholders to make sure that it will be able to meet all the contractual obligations of its existing policies. If the insurance company issues policies on applicants that represent risks that are uninsurable or risks that require premiums higher than the insurer may charge can cover, the insurer's ability to meet its contractual obligations is jeopardized.

On the other hand, a for-profit insurer wants to make money and to increase its number of policyholders. No insurer wants to reject applicants unnecessarily. All these factors must be taken into consideration in the underwriting process. An insurer is also regulated by the states in which it does business. The states expect the insurer to establish reasonable, non-discriminatory standards for accepting insureds. Rates for many types of insurance must be approved by the states in which the insurer does business. Regulation is another important factor in the underwriting process.

Establishing an Application File

When an application is received in underwriting, the insurer's underwriting process begins. The application is reviewed to make sure it is complete, and that the application, on its face, meets underwriting standards. At this point it is also determined whether or not additional documentation will be required. If additional documentation is required, the underwriting department will request the documentation, reports or inspections, or will notify the agent or agency that these items are needed.

Because the length of the underwriting process and policy issue is often governed by state regulations and company standards, the request for information, reports and inspections generally include a specified period of time in which the request must be fulfilled. If the information is not received within the specified time, the application file is generally closed, and any premium received is returned. Often the first review of the application includes the determination of whether the risk demonstrates appropriate insurable interest. Insurable interest must exist in order for the application to continue through the- underwriting process.

Insurable Interest

Often, the first characteristic of an acceptable insurance risk reviewed is whether it includes insurable interest. Requiring insurable interest helps to reduce the likelihood that the person or persons benefiting from the insurance will try, in some way, to cause or allow a loss. The definition of insurable interest varies depending upon the type of coverage being issued.

Under property insurance, the person who benefits from a property insurance policy must generally meet three requirements. He or she must:

1. Be in a position to suffer a loss related to the insured or the insured property,
2. Must not be in a position to profit or gain from a loss pertaining to the insured or the insured property, and
3. Must have a financial interest in protecting the insured from a loss.

Under life insurance, for insurable interest to exist, the death of the insured must have a clear and definite financial impact on the policy owner. Insurable interest in life insurance is considered to exist if the policy owner and insured are the same person. It is also considered to exist if the spouse of the insured is the policy owner, if a parent is the policy owner and the parent's child is the insured, if a grandparent is the insured and policy owner is a grandchild, if a business is the policy owner and the insured is a key employee or an officer or director of the business, and if business partners own policies on the lives of one another.

If a creditor is the policy owner and the debtor is the insured, there is insurable interest up to the extent of the debt only. Other relationships may include an insurable interest, but an underwriter is likely to ask for proof of such interest before accepting an application with an unusual insurable interest relationship.

Elements of A Valid Contract

Another important factor an underwriter will look for in any insurance application is verifying that it complies with rules surrounding legal and valid contracts. Insurance contracts, like all contracts, must include four elements in order to be legal and valid:

1. Consideration
2. Agreement or assent of the parties
3. Competent Parties
4. Legal purpose or legal subject matter

Consideration

Consideration is something of value that induces the parties involved into making a contractual agreement. Consideration may be monetary, or can be in the form of a promise or an act. Under an insurance contract, premium is the consideration.

Assent of Both Parties

Under contract law, parties involved in a contract must agree to contract terms as they exist. This legal concept is known as mutual assent. In order for a contract to be valid, agreement cannot be made under any kind of duress, by mistake, or by any fraudulent means.

Competent Parties

A competent party is one having the legal capacity to enter into a contract. A minor does not have legal capacity to enter into a contract, nor does a person who has been declared legally insane, or those who are under the influence of intoxicants.

Legal Purpose

Every contract must be entered into with a legal purpose. If a contract has an illegal purpose, it is void. Examples of illegal purposes that might be found in life insurance are policies opened with the intent to commit murder or to falsify the death certificate of an insured in order to collect the death benefit. In property insurance, a contract with an illegal purpose may be one entered into in conjunction with a contract with an arsonist to burn the property insured.

Property-Casualty Contracts

In property-casualty insurance, most states prohibit policy forms that include provisions, exceptions or conditions that are misleading, ambiguous, deceptive, overstate the coverage or misrepresent the coverage in the policy. States may also require that the policy contract include notices regarding the policy's cancellation or non-renewal. If the policy is a personal lines policy such as a homeowner's or personal automobile policy, it will generally have cancellation and renewal provisions that are more lenient for the consumer than a policy written for a business.

For example, the insurer may have to return premium to a non-business insured more rapidly than the insurer must return premium to the named insured on a business policy. States may also require that a declaration or information page be included in the policy form that identifies the individual insured, the property to which the insurance applies, any of minimum liability, and the effective date and time of policy inception.

The policy form may also be required to include a clear insuring agreement, conditions under which the coverage applies, exclusions from policy coverage, definitions of important words in the policy, a statement that bankruptcy does not relieve the insurer of its obligations, an arbitration clause, an appraisal clause and a statement that the policy form and endorsements constitute the entire contract.

Exempt Commercial Policyholders: Under some state insurance regulations, certain commercial policyholders are exempt from rate and form requirements that would normally be applicable. An exempt commercial policyholder under these regulations is one who is a sophisticated business purchaser. Such a purchaser is likely to study and understand insurance coverages, exclusions and the risks to which their business is subject.

An exempt commercial policyholder may be one requiring customized insurance coverage rather than coverage through a filed form from the insurer. To qualify as an exempt commercial policyholder, a state may require that the policyholder be of a certain size, for example, requiring that the business have a net worth of over a certain amount or requiring that net revenues or sales be over a certain amount. Other requirements may include that the policyholder employ a risk manager or pay annual insurance premiums of a certain minimum amount, such as at least \$500,000.

Insurable Risk

Another key aspect of each application reviewed by an underwriter is the determination if the risk the application represents is an insurable risk. Not all risks are insurable. As each risk is evaluated, it is important to note whether or not it can be insured. If not, insurance may not be purchased on the risk.

In order to be insurable, a loss must:

- Arise from a pure risk
- Be definable
- Be calculable,
- Not occur to many people simultaneously, and
- Not be Intentional.

Pure Risk

A pure risk is one which cannot result in the possibility of gain. In order to be insurable, a risk must have the potential of only two possible results: loss or no loss. If a risk includes the possibility of gain, it is called a speculative risk. Launching a marketing campaign is an example of a speculative risk.

It may result in a loss in sales if people are turned off by the advertising, it may result in neither an increase nor a decrease in business if the advertising makes no impact, or it may result in increased sales. Insurance policies do not provide insurance for speculative risks. Insurers protect against pure risks such as fire.

If no fire occurs, no loss occurs. If fire occurs, loss occurs. Liability claims or suits are pure risks. If a liability claim does not occur, no loss occurs. If a liability claim occurs, loss occurs, ranging from defense expenses to the payment of a damage award.

Definable Loss

Insurance covers losses that can be defined in terms of cause, time, place and amount. Cause must be definable in order to make sure that the coverage applies to losses arising from the cause.

Time must be definable in order to make sure the loss occurred during the policy period or whatever terms the policy provides regarding the period of time in which claims may be made.

Place must be definable to ensure that the loss occurred within the coverage territory stated in the policy. Amount must be definable so that the insurer pays the benefit due under the benefit limits of the policy.

Calculable Loss

Insurers must be able to calculate both actual and expected losses. Expected losses are the basis of premiums charged. Actual losses may result in an adjustment of premium in the preceding period and for ongoing coverage. Actual losses also are the basis for paying benefits from the policy.

Not Occur to Many People Simultaneously

In order to provide insurance, premiums must be collected from a large number of people exposed to the same type or types of loss. Even though the insureds are exposed to the same type of loss, the exposure for each insured must be independent. If all the insureds were exposed to loss by the same

fire; for example if they all operated businesses in connecting wood buildings on the same street the insurer would not have sufficient premium to pay for their losses should a fire break out.

In order for the insurer to pay all claims, losses must occur to a certain expected percentage of the insureds at a certain expected frequency. If a large number of the insureds are all affected by the same loss exposure, the insurer will either have to charge premiums of an amount that would make the insurance unaffordable or no more affordable than if the business were self-insured, or the insurer will not have sufficient premium collected to pay for losses suffered.

Unintentional Losses

Intentional losses are never insurable. First of all, intentional losses do not fit the models of probability used to determine premium amounts. Premium amounts are based on the frequency and severity of unintentional losses. Secondly, intentional losses may be criminal or fraudulent. Contracts must have a legal purpose. Insurance may not pay for losses which arise from illegal activity.

Applicable Factors for Underwriting

Once it is established that insurable interest exists, the application would result in a valid contract and the risk the application represents is insurable, the underwriters evaluate the basic characteristics of the risk. Each line of insurance is underwritten using pieces of information unique to that type of coverage. Most of the information is found on the application for the insurance, and additional data is provided through supporting reports, documents and inspections.

Under life and health insurance, information related to the medical history of the insured is weighed, as are the occupation and hobbies of the insured. Under property insurance, the property may be inspected or documents may have to be submitted that verify the value and condition of the property described in the application.

In liability insurance covering a business, site inspections and contracts used by the business, as well as other documents related to the business and its operations, may be required. Liability coverage for a home or auto insurance policy may also require an inspection of the property. Many forms of insurance require financial information to be submitted for the underwriting process.

When individuals are covered, personal financial records may be needed. When a business is covered, the business' financial statements are generally submitted. If a professional is covered, both personal and business financials may be requested.

Determining Rates

Once all the information pertaining to the application and supporting documentation is evaluated, the underwriters determine whether a policy should be issued, and if so, what premium should be charged. As was discussed in the last chapter, policies may generally be issued with standard rates, substandard rates or preferred rates.

Rate Determination Methods

In many cases, state insurance law directly impacts rate determination. Some states promulgate rates for certain lines of insurance, and the insurer must use these rates for the insurance they issue in

such lines. States may allow insurers to file rates for various lines of insurance. A range or band of rates is filed with the insurance department and the insurance company may use these rates and issue insurance once the insurance department of the state has approved the rate band. Another method states may allow is to require the insurer to file rates and then use these rates unless the insurance department in the state notifies the insurer that the rates are not allowable.

Insurers are required to give due consideration to past and prospective loss experience, to the type and scope of hazards, to a reasonable profit margin, to dividends and return of premium, to past and prospective expenses and to any special assessments when setting rates.

Judgment Rating

Within the parameters of state law, underwriters may use one of three methods to assign rates. One method is known as the judgment method. Judgment rating refers to the underwriter using his or her own knowledge and experience to determine the rate that should be assigned to the applicant. No specified rates are applied. This sort of rating is normally done for special lines of insurance or for lines of insurance that do not require rates to be approved by the state.

Manual Rating

A second method used to determine rates is more and more commonly used, especially in heavily regulated lines of insurance. This method is known as manual rating. Under manual rating, pre-determined rates found in manuals are used to set rates for each policy. Manual rates may be promulgated by the state insurance department, or may be developed within the insurance company or by a rating bureau.

Merit Rating

The third method of setting rates is known as merit rating. Under merit rating, manual rates are used and then modified based on specific characteristics of the risks. Modifications to rates may be based on the experience of the insured over a specified period prior to and sometimes including the policy period or on the experience of the specific insured during the policy period, or on a schedule that quantifies applicable risk characteristics.

Experience Merit Rating

When the experience of the insured over a specified period is used, the applicant is generally asked about relevant behavior or occurrences applicable to the insurance coverage. This type of merit rating is known as experience rating. For example, a driver may be asked about traffic violations that occurred during the last three years. Rates are based in part on the number of such violations over this period.

Retrospective Merit Rating

Another type of merit rating involves the underwriter reviewing the loss experience during the policy period and setting a rate based on that loss experience. This type of merit rating is known as retrospective rating. This sort of rate setting is often done in commercial lines of insurance and in Workers Compensation insurance.

Scheduled Merit Rating

A third type of merit rating, scheduled rating, is a sophisticated form of manual rating. Manual rates are used as the base rate, and rates are added or subtracted from this base rate based on amounts determined for various risk characteristics. For example, the use of certain fireproof construction materials may result in a reduction of the standard rate under this type of rating system.

Regardless of the type of method used to assign rates, rates are determined by evaluating the relative frequency and severity of a risk. Severity refers to the amount of financial loss that is likely should a risk occur. Frequency refers to the number of times a loss is likely to occur. A loss likely to be infrequent and small is "less expensive to the insurer than one" that may be infrequent and large, or one that is both frequent and large.

Competitive Markets and Rate Setting

Another component of rate setting regulations of many states is the determination of whether a competitive market exists. Some states require the insurance commissioner to evaluate the amount of competition offering various lines of insurance. The methods the insurance commissioner may take in determining the presence of a competitive market may include conducting hearings and tests pertaining to market structure, market performance and market conduct.

In a competitive market, consumers are able to easily compare insurance products and obtain insurance from competing insurers. Non-competitive markets may exist for high-risk insureds, such as those living in the path of severe windstorms, or insureds who have, or are statistically likely to have, a high number of claims. If a competitive market does not exist, the commissioner may be required under state insurance law to take steps to provide consumers within the non-competitive market with the ability to purchase insurance.

Actions a commissioner may take include requiring insurers doing business in the state to provide insurance products for people unable to purchase them in the normal marketplace. The commissioner may set rates for these products or mandate that rates be kept within a certain level. Another action that may be taken in states where it is determined noncompetitive market exists, is that the state will form an insurance pool to cover the needs within this noncompetitive market.

In insurance rate regulations, the definition of an excess rate may include the presence of or lack of a competitive market. For example, a regulation may state that insurance rates in a competitive market are automatically presumed not to be excessive. Also in some states, if a competitive market exists, insurers may not have to file rates to keep doing business in the state.

Such insurers may still have to file rates for information purposes and for use by the commissioner in determining that a competitive market still exists, but insurers within a competitive market may be exempt from the rate renewal filing requirements of insurers within a noncompetitive market.

Terms at Policy Issue

Besides setting specified rates, the applicant may be required to meet underwriting requirements in order for insurance to be issued or remain in force. For example, a business may be required to install a sprinkler system, a homeowner may be required to add railing to a deck, and an individual

with a valuable coin collection may be required to place it in a safety deposit box in order for the insurance to apply.

Underwriting Resources

Many resources are used during the underwriting process. The most important of these resources is the application.

Insurance Applications

The insurance application is a critical underwriting resource. From it, the underwriter finds most of the basic information needed to determine whether to issue a policy, and if so, at what premium and terms.

Life Insurance Applications

Each life application generally requires the following type of information:

- Applicant and insured name, address and other general information
- Medical information
- Agent's statement
- Selection of riders or optional features
- Signatures

General Information: The general information section of life insurance applications generally asks for the name, address, birth date, social security number and gender of the insured and owner. The relationship of the owner to the insured is also needed.

The name or names of beneficiaries is also requested, along with the percentage for each beneficiary or other beneficiary designation, and the relationship of each beneficiary to the owner. Some applications also require the beneficiary's social security number. This is to aid the insurer in identifying the proper beneficiary, if necessary.

Medical Information: Medical questions include asking whether tobacco or nicotine products have been used, and if the insured had been diagnosed, treated or hospitalized for:

- Cancer
- Heart attack
- Stroke
- Diabetes
- Kidney disorders
- Alzheimer's disease
- Liver disorder
- Organ transplant
- Alcohol or drug use treatments
- AIDS or HIV
- Irregular heart beat
- High blood pressure

- Fainting spells
- Emphysema or other chronic lung or respiratory disorder
- Inability to work for more than a week in the past six months or year
- Other similar questions

If there is a "yes" response to the medical questions asked, the application will generally ask for more details. Once the application reaches the home office, medical reports or an attending physician statement may also be requested. Or, the insurer may have issued underwriting guidelines to the agent who requests such reports through his or her agency office.

Replacement: Each application also asks whether this proposed insurance will replace or change any existing or pending insurance. If the applicant answers "yes" to this question, the agent may be required by state regulations to complete state replacement forms with the applicant.

State replacement forms generally include comparative information for the applicant to read regarding the proposed insurance and the policy to be replaced. They may also include disclosure statements for the applicant to sign indicating that the applicant understands that there may be surrender charges involved in canceling the existing policy, that the new policy generally includes commission loads and that a new surrender charge period may apply to the new policy. In insurance company required "1035 Exchange" or "Absolute Assignment" form must also be completed in a replacement situation.

Duties of Agents Regarding Replacement: The National Association of Insurance Commissioners, or NAIC, crafts Model Regulations regarding many insurance practices. The various states adopt these model regulations and may also amend them as their legislators find appropriate. Included in the NAIC's Model Regulation for Life Insurance and Annuities Replacement, are "Duties of Producers."

Under this Model Regulation, an agent who initiates an application is to submit to the insurer a statement signed by both the applicant and the agent stating whether the applicant has existing policies or contracts. This statement may be part of the application form or a separate document.

If the signed statement indicates that replacement is not involved, the agent has no further duties. However, if the applicant answered "yes" to the question regarding replacement under the Model Regulation, the agent must give and read to the applicant a notice regarding replacement in a form recommended by the NAIC, or a similar one approved by the insurance commissioner of the state in which the agent is doing business. The NAIC recommended disclosure form includes the following items:

- A place for the agent and applicant to sign for the receipt of the form.
- Definition of a replacement in consumer-friendly terms.
- A statement to the effect that the new policy may include acquisition costs and that surrender charges may apply to the existing policy.
- A place for the applicant to indicate the policy number and insurance company of the policy or policies which are to be replaced.
- A statement recommending that the applicant contact their existing insurance company or his or her agent for information about the old policy.
- A space where the applicant can indicate why the old contract is being replaced.

- Suggested questions for the applicant to discuss with both the new and old agent regarding: premium amounts and the length of time premiums must be paid; the surrender charges, expense and sales charges applicable to both policies; whether suicide limitations apply to the new policy; whether a medical exam must be undergone for the new policy and the current insurability of the applicant; how the interest rate guarantees and current crediting rate compare; and the tax ramifications of the transaction.

Under the Model Regulations, besides the notice, the agent is required to leave a copy of all sales material at the time an application for a new policy is completed, or if electronic material is used, no later than the time of policy issue.

Violations and Penalties: Also included in this Model Regulation are the ramifications of violating the Regulation. Examples of violations to the Regulation include:

- Deceptive or misleading information in the sales material
- A failure to ask the applicant the questions regarding replacement
- Intentionally recording an incorrect answer
- Advising an applicant to give a negative answer regarding questions about replacement in order to keep from having to notify an existing insurance company
- Advising an applicant to contact the existing insurer directly so that the replacing agent or company is obscured

If an agent has a regular pattern of having customers say they are not replacing insurance contracts on an application, and then afterward replaces the insurance contracts, the Model Regulation states that such action is considered "prima facie" evidence of the agent's intent to violate the regulation.

Under the Model Regulation, violators of the Regulation are subject to penalties that may include the revocation or suspension of an agent's or company's license, monetary fines and the forfeiture of any commissions or compensation paid to a producer related to the transaction in which the violations occurred. In addition, the insurance company may be required to make restitution, restore policy or contract values and pay interest at a specified rate on the amount.

Agent Statement: The agent has a responsibility to the insurer to report to the insurer on the application to provide information the insurer requests, such as how long the agent has known the applicant, whether the agent has knowledge that the proposed insurance is being purchased to replace existing insurance and to supply basic information the agent has knowledge of regarding the applicant's health, financial situation and general character.

Selection of Features and Options: Depending on the type of policy applied for, the applicant will make several choices regarding the insurance coverage. All policies, other than single premium policies, generally provide a choice of payment frequency, including monthly, quarterly, semi-annual or annual payments. Many insurers offer the option of pre-authorized checks so the premium amount may be withdrawn directly from the applicant's bank account.

If the policy is to include any riders, the applicant must indicate his or her selection. If the policy has an option of death benefits, the applicant must also select the death benefit option desired. If the policy includes variable sub-accounts, the applicant must select the initial sub accounts into which cash values will be placed and the percentage to be placed into each one. Variable policies may also

offer the ability to make telephone transfers among sub accounts and other similar features the applicant must authorize.

Occupation/Hobbies: If the applicant is involved in certain occupations or hobbies, or is surrounded by certain sets of circumstances, a completion of a questionnaire designed for that occupation, hobby or circumstance may be required by the insurance company. Examples of items that may require the completion of a questionnaire include involvement in aviation, skydiving, military service, having foreign residency, and being in certain finance related occupations.

Disclosures: Applications or accompanying documents also include disclosures regarding the Medical Information Bureau and the Fair Credit Reporting Act. The applicant must sign indicating receipt of these notices. The applicant must also give the insurer written permission to obtain consumer and investigative consumer reports. Another important responsibility of insurance agents is to supply buyer's guides in accordance with state regulations. The agent must also be prepared to answer the consumer questions included in buyer's guides.

Dividend Options: If a life insurance policy is a participating policy, the application will include a section regarding the owner's dividend options. A participating life insurance policy participates in the earned surplus of the insurance company. Dividends may be paid to policy owners from such policies.

Dividends may result from the insurer paying out claims in amounts that are lower than expected. This condition is known as positive experience. Dividends may also be paid because investment earnings are higher than expected or expenses are lower than expected.

However, dividends do not have to be paid under such circumstances. They are paid at the discretion of the insurer. Options for dividend payments generally include:

- Payment in cash
- Reduction of premium due
- Leaving on deposit
- Purchase of paid-up additions
- Purchase of term insurance

Receipt: Once the applicant has completed and signed the application, in some cases, the applicant gives the first premium check, made out to the insurance company, to the agent. The agent then gives a receipt to the applicant. In other cases, the first premium is not collected until policy delivery.

Submission to Underwriting: The agent is then responsible to submit the application and any premium received to the insurance company.

Health Insurance Applications

Health insurance is often issued under a group policy through an employer. An application for coverage under a group policy is often simpler than an application for individual coverage, but both types of applications ask similar information. A group application from an employer will normally include the following elements:

- Employer name

- Employer plan group number
- Employee name
- Employee address and phone number
- Date of hire
- Employee position or title
- Sex of the employee
- Birth date of the employee
- Marital Status
- Whether the employee uses tobacco
- Whether the application for coverage is based on COBRA (this is a federal law requiring the ability of terminated employees to continue health coverage under certain circumstances)
- Deductible amount if any
- Coverage options, such as whether dental coverage or prescription drug coverage is to be included
- Dependent coverage information for spouse and children
- Prior coverage information (this information is necessary to comply with federal health coverage rules for group policies)
- Medical information
 - Height and weight of adults covered
 - Whether any insured has had medical treatment for his or her back, colon, liver, kidney, diabetes, intestinal tract, muscular system, respiratory system, heart or circulatory system, or for any cancer, convulsions, a stroke or mental or emotional issues
 - Whether treatment had been received for alcohol or drug use
 - Whether the applicant had been diagnosed or treated for HIV, AIDs or ARC o Whether the applicant or any insured is pregnant
 - Whether there has been treatment or diagnosis related to any insured's ear, eye, joint, ulcer, rectal, hernia, allergy, asthma, arthritis, breast, thyroid, prostate, headache, gallbladder, urinary tract, digestive system, reproductive organs, or high blood pressure
 - Whether any insured has any other medical condition not included elsewhere in the application
 - Request for additional explanation on any medical condition indicated on the application

The information on the health insurance application is necessary for the underwriters to properly underwrite the coverage. In the case of group insurance, the items related to the employer and the employer plan group number is used for the basic purpose of placing the employee within the proper group plan. Date of hire and position in the firm is used to make sure the employee is identified correctly and because under some benefits programs, the amount the employer pays for health benefits varies based on the length of time an employee is on the job and the position of the employee.

Applications include a question regarding whether the coverage is based on COBRA because COBRA coverage is governed by federal laws. The insurer must make sure that all these laws are complied with if the health coverage does fall under COBRA. Prior coverage information is also important because both federal and state law requires that certain waiting periods and exclusions may be reduced through the application of prior coverage periods.

Optional coverages such as dental and prescription drug impact rates and terms of the coverage applicable to the insured. The age, sex, marital status and use of tobacco ail relate to characteristics

of the risk that are used to determine rates for the health coverage. The more detailed health questions also are used to determine the type of health risk the applicant represents. Depending upon the answers given, the underwriter may need additional information, such as attending physician statements and other medical reports.

Disability Income Applications

Disability income insurance is a form of health insurance, but includes important factors not relevant in other forms of health insurance such as medical expense coverage. Disability income insurance provides payment if the insured becomes disabled as defined under the policy. Underwriting in disability income insurance does not just look at the current health and health history of an insured, but also attempts to determine less easily documented risk characteristics related to the motivation of an insured to return to work should a disability occur.

Disability income insurance applications generally include the following items:

- Age of the insured
- Sex of the insured
- Occupation of the insured, including details regarding the insured's position
- Medical history
- An explanation of medical conditions, including their frequency, severity and likelihood of recurrence
- Height and weight of the insured
- Blood pressure and other health indicators
- Financial information such as the applicant's income, unearned income and net worth
- Mental health history
- Treatment for drug or alcohol use
- Prior coverage history
- Claims history

Disability income insurance applications include information regarding the medical history and current health conditions of an applicant that is similar to that found on other health insurance applications. However, disability underwriters are more concerned about whether or not a medical condition will lead to disability than are underwriters of other forms of health insurance.

Disability income insurance applications also include information regarding the financial status of an applicant that is not found in other forms of health insurance.

This is because disability underwriters attempt to issue policies with benefit levels that do not encourage an insured to submit claims in order to better their financial position. Even the most generous disability income benefits are generally designed to meet basic income needs of the insured, not to give an insured a higher income than he or she would have had if the insured had been able to keep working.

Disability income policies also include information regarding the position of the insured within a business. Individual disability income policies are often marketed to owners of businesses, professionals or key executives.

One reason that disability insurers look for such individuals to purchase their policies is that such individuals are generally highly motivated to return to work, meaning that disability income payments may not continue as long as they would for someone with less motivation to return to work.

Long-Term Care Insurance

The common underwriting factors included on a long-term care insurance application are the following:

- Age
- Sex
- Medical History, including
 - Heart attack
 - Diabetes
 - Cancer
 - High Blood Pressure
 - Arthritis
 - Renal disease (kidney failure)
 - Respiratory distress that requires oxygen use
 - Schizophrenia
 - Dementia
 - Spinal cord disorders
 - Multiple strokes
 - Systemic lupus
 - Most recipients of transplants
 - Tuberculosis
 - Multiple episodes of fainting
 - Severe growths or tumors
- Current medical condition
- Whether the insured has undergone drug or alcohol abuse treatment
- Family medical history
- Occupation

Long-term care insurance underwriting, as a form of health insurance, involves reviewing medical and health factors. Statistics related directly to long-term care are used to evaluate each risk and establish rates. For example, the sex of the applicant is important because women, due to having a longer life expectancy than men, are more likely to need some type of long-term care services.

Each type of medical condition an applicant may have is thoroughly scrutinized in long-term care insurance underwriting. The frequency and severity of the individual's condition is evaluated to determine insurability and applicable rates. For example, if an applicant has diabetes, yet does not have to take insulin or is on low doses of insulin, the underwriter may still deem the applicant as insurable. However, more advanced cases of diabetes may render an applicant uninsurable.

Certain types of medical conditions or behaviors may cause a long-term care application to be rejected. Drug abuse, alcoholism, kidney failure, schizophrenia, dementia, spinal cord disorders, multiple strokes, systemic lupus, tuberculosis and severe growths or tumors may cause an applicant to be deemed uninsurable.

Homeowners Application

Homeowners applications generally include the following information:

- Applicant's name
- Applicant's address
- Type of coverage requested (actual cash value, replacement cost, or other)
- Location of home
- Details regarding the home, including
 - Year built
 - Square footage of dwelling
 - Square footage of adjacent structures
 - Number of families
 - Number of stories
 - Type of roof
 - Value of personal property
 - Whether the home includes a wood stove
 - Construction type (masonry, wood, other)
- Location of fire station, hydrant and fire district
- Mortgagee/Loss Payee information
- Additional coverage information (e.g. earthquake coverage)
- Discounts for which the homeowner qualifies
- Prior/Current Insurance Carrier and policy information
- Whether the homeowner has filed or is filing for bankruptcy
- Whether the homeowner is delinquent on house payments or taxes
- Whether anyone with a financial interest in the property has been convicted of fraud, arson or any other crime on property over the past five (or other specified time) years
- Whether there is a pool, and if so, if it is fenced
- Whether there is a pond, lake or dock on the premises
- Whether there is a hot tub on the premises
- Whether there is a trampoline on the premises
- Whether there are animals on the premises, and if so, what breed and if there has been a history of biting
- Whether there is a business on the premises, and if so, what type
- Description of other structures on the premises Whether the electric service is on circuit breakers
- Whether the home is the primary residence of the insured
- Whether there is existing structural damage
- Whether there are smoke detectors on the premises
- Whether there is brush or landslide exposure
- Type of wiring and plumbing and roofing
- Whether the property has been inspected by the agent
- Space for additional documentation, including photos of the property

The information on homeowners applications is used to determine insurability and rates under both the property coverage and liability coverage provided under homeowners policies. Items such as the location of the home, the construction materials used, and the age of the home most directly affects

the property coverage. Insurance maps used by the underwriters help to determine the risk of fire and theft the homeowner may experience due to its location and are used for property insurance underwriting.

The physical condition of the home, whether a pool, hot tub or trampoline are on the premises are more important factors for the liability insurance underwriting aspects of the policy.

Personal Automobile Application

Applications for personal automobile insurance generally include the following:

- Name and address of the named insured
- The year, make and model of autos to be covered
- Current automobile policy information
- Whether the autos are used for business or pleasure
- Whether the autos are used to drive to and from work and if so, how many miles to work
- The annual mileage of the autos to be covered
- Information on the drivers of the autos, including:
 - Driver's name
 - Driver's marital status
 - Length of time as drivers
 - Whether the drivers had any at fault claims, traffic violations or a loss of license in the last three years
- Amount of liability, collision and comprehensive coverage desired

Factors used in automobile insurance underwriting include the age of the driver, the sex and marital status of the driver and the driver's record. Statistically, single persons tend to have more accidents than married persons and younger people, particularly younger males, tend to have more accidents than do older adults. The amount of miles the auto is driven also has been statistically determined to impact the likelihood of an accident involving the automobile. The type of automobile or automobiles covered impacts the amount of damage the automobile is likely to cause to another auto, and the safety of the driver and passenger. Likelihood of theft is also based on the make and model of the automobile insured and where it is garaged.

Commercial Automobile Application

Commercial automobile applications are completed by a named insured on behalf of the business owning the covered automobiles. These applications generally include the following factors:

- Name and address of named insured
- Garaging address of vehicles
- Type of business (individual, partnership, corporation, or other)
- Length of time business has been in operation
- Description of business operations
- Business' gross receipts for the current and past year
- Type of commodity transported
- Whether there is any exposure to flammables, explosives, chemicals or hazardous materials

- Area of business operations
- States in which vehicles are operated
- Large cities in which vehicles are operated
- Whether or not the business hauls cargo for others, and if so, details of such
- Whether vehicles are parked at a jobsite most of the day
- Whether vehicles are loaned, rented or leased to others, if so, under what terms
- Whether vehicles are loaned, rented or leased from others, if so, under what terms
- Whether vehicle owner/operators are used, and if so, under what terms
- Whether sub-contractors are used, and if so, under what terms
- Whether any employees use their own vehicles for the business
- Whether any family members use company-owned vehicles
- Whether passengers are allowed to ride in vehicles
- Whether all drivers are covered by Workers Compensation coverage
- Driver information, including:
 - Whether drivers are employees
 - Whether drivers are paid by the hour, by the load, or some other way
 - Whether there is a formal driver safety program
 - The maintenance program in place
 - Whether drivers are screened upon hire
 - Specific driver information, including name, driver's license number and other specifics
- Vehicle information, including:
 - Type and number of vehicles owned
 - Type and number of vehicles leased
 - Specific vehicle information, including model, type of vehicle, seating capacity, driving radius and garaging location
- Information regarding federal and state vehicle permits
- Prior loss information
- Policy limit and coverage information

Many of the items included in a commercial automobile policy are the same as those found in personal auto policies. The make and model of vehicle, where it is garaged and the drivers' records are all important underwriting factors. In addition, the territory in which the auto is used, and the cities in which it is driven are taken into consideration because more accidents occur in some places than in others. Some of the questions on the application are used to determine if endorsements should be utilized in the coverage.

For example the liability coverage of commercial auto policies exclude autos owned by employees. If employee-owned autos are used in the business, the business owner may want to add liability coverage for such autos through an endorsement. State and federal permit information is requested to make sure the business is in compliance with state and federal laws regulating the use of the vehicles, and to provide underwriters with information regarding the use of the vehicles.

Commercial Property Application

Applications for commercial property coverage generally include:

- The name of the named insured
- The address of the named insured and the business owning the property to be covered

- Location of all property to be covered
- Description of property to be covered
- Value of property covered
- Security devices and other loss control measures related to the property
- Current amount of insurance in force on the property
- Whether the insurance currently applied for is to be in addition to the current insurance, or will replace the current insurance
- Loss history in the prior three years
- Date of site inspection and place to attach site inspection report

The information on the commercial property application is used to determine the exposure to property risks of the property. Property coverage generally protects against the perils of fire, lightning, explosion, theft, windstorm, hurricane, hail, riot, civil commotion, smoke, aircraft, and land vehicles, as well as other perils as defined by the policy.

The location of the property is evaluated to determine its statistical risk of fire, windstorm, and other weather related perils. Location is also important in determining the risk of theft and vandalism. The type and value of personal property is also evaluated for the level of applicable risk exposures.

Site inspections are an important part of commercial property coverage and reports of site inspections may be submitted as part of the application. Site inspections are used to verify the type, condition and value of the property. Also from site inspections may come various underwriting requirements, such as requiring the installation of safety or security equipment.

Commercial General Liability Application

General liability and business owners liability forms cover certain types of liability, but exclude liability that arises out of professional acts (errors) or failure to act (omissions) while conducting professional services. The types of liability protection offered by a general liability or business owners liability form include bodily injury and property damage liability and personal and advertising injury liability.

These liability forms also cover medical expenses arising out of bodily injury on the insured's premises, or on the ways next to the insured's premises, or arising from the insured's operations. A general liability application generally includes the following:

- Description of the business premises and operations to be insured
- Type of business to be insured (individual, partnership, corporation, joint venture, limited liability company, non-profit or other)
- The name and phone number of person to contact for an inspection and audit of accounting records
- Description of management experience
- Number of employees
- Whether there is:
 - Exposure to flammables, explosives, chemicals?
 - Exposure to asbestos?
 - Exposure to radioactive materials?
- Whether operations involve storing, treating, discharging, applying, disposing or transporting of hazardous material (e.g., landfills, wastes, fuel tanks, etc.)?

- Whether sporting or social events are sponsored?
- Whether the business owns, hires or leases watercraft, docks, or floats
- Whether any operations have been sold, acquired, or discontinued in last five years
- Whether the applicant a subsidiary of another entity or does applicant have any subsidiaries
- Whether any machinery and equipment is loaned and rented to others
- Whether there is a swimming pool on the premises
- Whether parking facilities and owned or rented
- Whether a fee is charged for parking
- Whether the applicant has in force Workers Compensation coverage
- Whether subcontractors are used and if so, if certificates of insurance are required from all subcontractors
- Whether the applicant leases employees
- Whether the applicant plans any structural alterations to the property
- Whether recreational facilities are provided for employees
- Coverage and loss history
- Schedule of hazards and whether they are products/completed operations or premises/operations hazards

The application for commercial liability insurance is used to help determine the type and nature of liability risks to which the business is exposed. The rates to be applied to the application will vary based on the type of liability risks that exist. For example, a business that deals with hazardous materials will be charged higher rates than a business dealing with cardboard boxes or other non-hazardous materials.

The insurer may also need to amend or endorse their basic policy coverage based on the specific liability attributes of the business. They may need to add a pollution liability endorsement or a builders risk endorsement, for example.

Professional Liability and Errors and Omissions Application

Applications for professional liability and errors and omissions insurance can require very detailed, complete information. They may require specific descriptions of functions performed and the amount of time dedicated to each function. Past employment may have to be documented carefully. The reason for the thoroughness of the applications, especially for certain occupations, is the high amount of risk the insurer may be underwriting. The insurer wants to fully understand the scope of the risk being insured in order to charge appropriate premium, or in some cases, in order to refuse certain cases.

Name and Address

Each application includes the name and address of the applicant for the policy.

Type of Business Entity

The application also asks for the type of business entity - sole proprietorship, partnership, corporation, and so on.

Limit of Liability

The amount of coverage requested is listed. The applicant may be able to choose from a wide range of coverage amounts, from \$100,000 or \$500,000 in coverage to \$1,000,000 or \$5,000,000 or more.

Deductible

Deductibles may range from zero for lower limit policies to as much as \$100,000 or more. Generally, the higher the deductible, the lower the premium charges will be. It is not uncommon for professionals who must carry high levels of expensive insurance, such as surgeons, to have a deductible of \$100,000.

Professional Services Description

Each application will ask for some form of description related to the professional services involved. The application may include several possible functions involved in the occupation and ask the applicant to indicate which functions apply and what percentage of time is spent in or percentage of income results from each function.

For some occupations this portion of the application can be quite lengthy. An application for a lawyer may include fifty or more different types of law practices to which the applicant must assign a percentage.

Other Business Activity

If the applicant is involved in functions or activities not listed, these activities must also be disclosed and a percentage of time or income assigned.

Controlling Interest

The application may ask if the insured or other party has a controlling interest in the business.

Gross Revenue/ Projected Revenue

The application may ask for the amount of gross revenue which the professional or practice has earned. This helps the insurer and the agent to determine the appropriate amount of coverage. The insurer does not want the applicant to be covered by either too little or too much insurance.

Special Risks

If there are special areas of risk involved in an occupation, the application will include questions related to them. An application for a lawyer may ask about work related to securities transactions and whether the lawyer has any outside director or officer responsibilities. A physician's malpractice form may ask about certain types of surgeries or medical procedures.

Questions related to special risks and about important procedures in the firm or practice may also be included in the application. For example, record keeping is essential in many professions. The application may ask for details of the record keeping process within the business.

If fees are collected and money disbursed, the internal controls surrounding collection and disbursement may be inquired about. If a computer software risk is being underwritten, backup and other data safeguarding procedures may have to be explained on the application. The applicant should be as complete and accurate as possible when answering these items.

Years in Business

The insurer is interested in the stability of a business. The application asks for the number of years the business has existed. If the business is a new business, it may qualify for premium discounts. If it has been in existence for some time, the insurer is interested in knowing whether there has been continuous liability coverage in force.

Professional Qualifications

Another way in which the insurer assesses the risk of underwriting the professional or firm is by asking about the qualifications of the professionals being insured. Education, continuing education and any special credentials may be asked about.

Professional Associations

The insurer may be interested in knowing whether the insured belongs to any professional associations. Professional associations generally provide education and may require special standards of conduct in order to belong.

Use of Written Contract

If the applicant uses contracts to transact business, the insurer may ask questions related to limiting liability through contract language. As has been mentioned, some insurers reduce premium if liability is limited contractually.

Employees

The application will ask for information regarding the type and number of employees to be covered. This information may be used to determine the risk and related premium for employer liability and employment practices liability.

Contractors or Subcontractors

Certain forms may ask for information regarding the use of contractors and subcontractors. Forms for engineering firms, for example, may include questions related to subcontractors. The insurer may want to know whether contractors and subcontractors are required to carry their own liability policies.

Other Insurance

Other insurance currently in force which covers the liability of the professional is of interest to the insurer. Remember that the insurer wants to reduce the risk of moral hazard. The applicant should not have more insurance than is necessary for the risk to be appropriately covered.

Prior Insurance

Types and amounts of prior insurance are important information for the insurer. The insurer is interested in knowing if the insurance was occurrence based or claims based and if any extended reporting periods are in force.

Prior Claims

The insurer also wants details on prior claims. The insurer needs to be aware of any known exposures. If there is still exposure related to a prior occurrence, the insurer may attach an endorsement to the policy, specifically excluding claims related to that occurrence. The insurer will also ask whether the insured has knowledge of any act, omission or error that could result in a professional liability claim.

Legal or Disciplinary Action Against Applicant

If any applicant has had any legal or disciplinary action made against him or her the details of the action must generally be disclosed to the insurer. If there are documents, such as copies of court orders or of a complaint, these are normally sent to the insurer along with the application.

Notice to the Applicant

Finally, the application will generally include a notice to the applicant. The notice requires the applicant to read the information and sign the application only if the applicant agrees to the representations made. The representations generally include that:

- The applicant declares that the answers in the application are true and that no material fact has been omitted;
- The applicant has disclosed any matters which could result in a claim; and
- The form is an application and not a guarantee of insurance.

The notice also generally includes the important statement that any person who knowingly and with intent to defraud any insurance company files an application with false information or conceals information regarding a material fact commits a fraudulent insurance act.

Special Coverages

If any additional coverages or endorsements are to be included, questions related to these coverages must also be completed on the application.

Inland Marine Personal Property Applications

Inland Marine Personal Property insurance, or personal property floater insurance, is often used to cover personal property in amounts greater than such property is covered through a homeowners policy. Such applications include the following information:

- Applicant name
- Applicant address
- Location of property (dwelling, apartment, condominium, mobile home, other)
- Occupation of members of the household
- Marital status of applicant
- Whether the location includes burglar alarms
- Whether the location includes any safes
- Security surrounding location if an apartment or condominium
- Whether property is located within one mile of a coast
- Whether the property is exhibited
- Whether the property is used in a business or commercially
- Where property is stored
- Loss history
- Coverage history
- Schedule of property to be insured, including:
 - Jewelry
 - Jewelry in Vault
 - Furs
 - Fine Arts
 - Cameras
 - Musical Instruments
 - Silverware
 - Stamps
 - Coins
 - Golfer's Equipment
- Direction to attach appraisals and bills that verify the value of the property to be insured
- Description of any property in mini-storage and description of storage facilities Personal property floater applications generally deal with valuable property. Often such applications must be accompanied by appraisal documents, bills and receipts that verify the property's value. Because the property is valuable, information regarding the safekeeping of the property is very important as well.

Ocean Marine Application

Ocean marine insurance is used to cover goods transported over the ocean and protects against perils of the sea. It is one of the oldest forms of insurance coverage. The application for such insurance may include the following:

- Name of the insured (often called assured in this form of insurance, and often a business)
- Address of the insured
- Type of business

- Type of cargo shipped and the percentage of each type as part of annual shipments. Type of cargo the insurer may ask may include:
 - General Merchandise
 - Branded Goods
 - Precision instruments
 - Machinery
 - Bottled products, excluding beverages
 - Non-Perishable Food Items / Pharmaceutical Products
 - Bottled Beverages
 - Automobiles and other Motor Vehicles
 - Household Goods and Personal Property
 - Frozen Food (other than Frozen Meat)
 - Frozen Meats
 - Chemicals
 - Fine Arts, Antiques and Similar Items
 - Steel Sheets, Coils, Bars, Billets and Similar Items
 - Yachts
 - Computers, Mobile Phones and Similar Items
- Prior premium and loss history
- Primary shipment departure and arrival points
- Maximum value of any shipment
- Percentage of shipments representing full container loads, partial container loads and by break bulk
- Percentage of shipments shipped by sea, air and by land
- Further explanation of any item on the application

Ocean marine coverage may be issued on a per shipment basis, or may be issued to cover all shipments from the insured. The latter method is used when an insured's shipments do not vary dramatically. If insurance is provided on a case-by-case basis, the details of the shipment must be scheduled, or listed, in the policy.

Workers Compensation Application

Workers Compensation applications are completed by the business that will provide the coverage for employees and generally include the following information:

- Name of the insured
- Address of the insured
- Type of business
- Years in business
- Total number of employees
- Number of full-time employees
- Number of part-time employees
- Number of employees under 18
- Number of employees over 65
- Number of employees who work from home
- Number of employees who drive employer-owned vehicles
- Whether the employer provide group transportation by employer-owned vehicles

- Whether the employer uses sub-contractors, and if so, the number of them
- Payroll information by class and payroll (typically based on regulating state statute)
- Excluded corporate executives (if state law allows the option for such people to be excluded from Workers Compensation coverage)
- Information related to workplace safety programs, such as:
 - Whether the business has a safety program
 - Whether safety meetings are held and if so, how often
 - Whether new employees participate in safety training
 - Whether injured employees are offered modified work
- Information related to the Workers Compensation claims process in place at the business
Workers Compensation rates are based on job classifications and set by the state in which the Workers Compensation policy applies. Each job is assigned a classification code, and each code has a rate, with higher risk jobs being assigned a higher rate. The premium is based on each \$100 of payroll multiplied by the applicable rate. Underwriters then often use a retrospective rating process to adjust rates each policy year. Also affecting rates is the utilization of rehabilitation. If an employer has a rehabilitation program which retrains employees or provides physical exercise and therapy, rates may be reduced by the insurer.

Medical Reports

Besides the application, the underwriters have other resources they may utilize during the underwriting process. For life and health insurance, the medical history of the insured must be examined. The application for the policy includes questions pertaining to basic medical information, including age, height, weight and health history of the applicant and the applicant's family.

Besides the application, if the coverage amount requested is above an insurance company's non-medical limit, additional medical information may be requested through a medical report. Generally, a medical report may be completed by a paramedic or a registered nurse. If there is information in the application or medical report that requires further explanation, an attending physician's statement, or APS, may be required.

An APS must be completed by a physician who treated the medical condition under question.

Attending Physician Statement: An APS is a questionnaire sent to the applicant's doctor. The doctor must complete the questionnaire in order for the underwriters to complete the underwriting process. The proposed insured must give his or her permission on the application for the attending physician to provide this information.

An attending physician statement is a relatively simple document. It generally includes:

- Patient's (insured's) name
- Patient's address
- If related to an insured's employment, a statement for the physician to designate whether the patient is able to return to work, and if unable, when it is anticipated the patient will be able to return to work
- An area for the physician to indicate the physician's diagnosis and prognosis.
- An area for additional remarks for the physician
- The physician's name, license number, address, phone number and signature

The Medical Information Bureau: Besides medical reports and APS reports, insurers have access to medical information through the Medical Information Bureau, Inc. or MIB. The MIB is an association of most life and health insurers in the United States. The MIB contains information about the medical condition of applicants and insureds. Applicants must currently authorize the release of information to the MIB.

The information may only be used for underwriting and claims purposes, and medical information is released only to the applicant's physician, or directly to the applicant if the applicant requests. The Medical Information Bureau is considered to be an important tool of the insurance industry because of its role in reducing fraud. By keeping track of important pieces of information used in the application and underwriting of life, health, disability and long-term care insurance, it is more difficult for applicants to falsify applications and claims.

Reducing false applications and claims means that premiums do not have to be raised for everyone who purchases such insurance due to fraud that has been discovered through the use of the MIB.

Inspection, Consumer and Credit Reports

If an applicant applies for amounts of insurance above certain levels, the insurer may conduct inspection reports and/or acquire credit reports on the applicant. An inspection report is created from interviews with an applicant's neighbors, associates and employees, and sometimes with the applicant as well. The inspection report and interviews are conducted by national investigative organizations hired by the insurer. Insurance companies request inspection reports in order to get a better understanding of an applicant's overall character, lifestyle, financial situation and risks to which an applicant may be exposed.

Consumer Reports: Credit reports provide information about the financial condition of an applicant. This is important to an insurer because insurance involves a financial commitment from the policy holder. If an insurer accepts policies from people with poor credit, or credit below a certain standard, policy lapses are likely to go up. Lapses cause an increase in expenses to the insurer who has incurred policy issue expenses associated with the policy.

Credit and consumer reports are regulated by the Fair Credit Reporting Act. This Act was originally enacted in 1970 and has been amended by other legislation since that time. It is important that agents understand the regulations applying to insurers from the Act so that agents are careful to follow the disclosure requirements that the insurer has put in place in accordance with these laws and so that agents can answer questions from customers asking to what use insurers are able to put these reports.

The Act regulates consumer reports and investigative consumer reports. Under the act a consumer report is defined as follows:

Consumer report:

1. In general. The term "consumer report" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of

living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumer's eligibility for

- A. Credit or insurance to be used primarily for personal, family, or household purposes
- B. Employment purposes
- C. Any other purpose authorized under section 604 [§ 1681b]

2. Exclusions. The term "consumer report" does not include

- A. Any . . .
 - I. Report containing information solely as to transactions or experiences between the consumer and the person making the report
 - II. Communication of that information among persons related by common ownership or affiliated by corporate control
 - III. Communication of other information among persons related by common ownership or affiliated by corporate control, if it is clearly and conspicuously disclosed to the consumer that the information may be communicated among such persons and the consumer is given the opportunity, before the time that the information is initially communicated, to direct that such information not be communicated among such persons
- B. Any authorization or approval of a specific extension of credit directly or indirectly by the issuer of a credit card or similar device;
- C. Any report in which a person who has been requested by a third party to make a specific extension of credit directly or indirectly to a consumer conveys his or her decision with respect to such request, if the third party advises the consumer of the name and address of the person to whom the request was made, and such person makes the disclosures to the consumer required under section 615 [§ 1681m]
- D. (D) A communication described in subsection (o).

The Act also defines "investigative consumer reports," which the insurance industry generally refers to as "inspection reports:" The term "Investigative consumer report" means a consumer report or portion thereof in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with neighbors, friends, or associates of the consumer reported on or with others with whom he is acquainted or who may have knowledge concerning any such items of information.

Such information shall not include specific factual information on a consumer's credit record obtained directly from a creditor of the consumer or from a consumer reporting agency when such information was obtained directly from a creditor of the consumer or from the consumer.

Permissible Purposes of Consumer Reports: Under the Fair Credit Reporting Act, consumer reports may only be furnished for certain purposes by consumer reporting agencies. One of these permissible purposes is furnishing a report to a person the consumer reporting agency has reason to believe intends to use in connection with the underwriting of insurance.

Use of Consumer Reports: Under the Fair Credit Reporting Act, a consumer reporting agency may only issue a consumer report that is not initiated by a consumer request if the consumer authorizes the agency to provide the report or the transaction for which the consumer report is used is considered a "firm offer of insurance."

If a consumer report is issued because the transaction is a "firm offer of insurance" and is not authorized by the consumer, the report may only furnish the name and address of the consumer, an identifier used solely to verify the identify of the consumer and other information pertaining to the consumer that does not provide the relationship of experience of the consumer with a particular creditor or other entity.

Items That May Not Be Included In Consumer Reports: Consumer reports initiated by the consumer or authorized by the consumer may not generally include:

- Bankruptcy that occurred more than ten years before the report
- Civil suits, civil judgments and records of arrest that were recorded by the greater of seven years before the report of the governing statute of limitations has expired
- Paid tax liens that were paid more than seven years before the report
- Accounts placed for collection or charged to profit or loss more than seven years before the report
- Any adverse information, other than records of convictions of crimes, that occurred more than seven years before the report

Disclosing Investigative Consumer Reports: In order to have an investigative report prepared, it must be clearly and accurately disclosed to the consumer than an investigative consumer report, that includes information about the consumer's character, general reputation, personal characteristics, and mode of living, may be made. The disclosure to the consumer must:

- Be in writing
- Be mailed or delivered to the consumer not more than three days after the date the report was requested
- Include a statement that the consumer has the right to request information about the nature and scope of the investigation.

If the consumer requests information about the nature and scope of the investigation, the person who caused the report to be prepared must comply with the consumer's request in writing no later than five days after the request was received.

Disclosures to Consumers: The Fair Credit Reporting Act and related legislation also requires that reporting agencies, upon request from the consumer, disclose:

- All information in the consumer's file at the time of the request, other than credit scores or similar risk predictors
- Sources of information, other than information used solely for an investigative consumer report which must be available if needed for the discovery process in an applicable court case
- The identity of each person who procured a consumer report generally in the last one year period only
- Dates, original payees and amounts of any checks upon which is based any adverse characterization of the consumer

A consumer reporting agency must also include a "Summary of Rights" with the disclosure to the consumer. A Summary of Rights includes:

- A brief description of the Fair Credit Reporting Act and all consumer rights within it;
- An explanation of how a consumer may exercise rights under the Fair Credit Reporting Act;
- A list of Federal agencies responsible for the enforcement of the provisions in the Act, including addresses and phone numbers;
- A statement that the consumer may have additional rights under State law; and
- A statement that a consumer reporting agency is not required to remove accurate derogatory information from a consumer's file that is in compliance with the Act.

Disputed Information: If a consumer disputes the information from a consumer reporting agency, the consumer reporting agency must reinvestigate the information free of charge.

The consumer reporting agency must then record the current status of the disputed information or delete inaccurate information, generally within thirty days from the date the consumer reporting agency receives the notice of dispute from the consumer. In some cases, the consumer reporting agency can deny reinvestigation because it determines the request is frivolous or irrelevant. If information in a consumer's file is found to be inaccurate or unverifiable, the consumer reporting agency must promptly delete the item or modify it as applicable.

Special Restrictions On Investigative Consumer Reports: If a consumer reporting agency prepares a subsequent investigative consumer report on the same consumer, it cannot include any adverse information in the report, other than matters of public record, unless the adverse information has been verified during the process of making the subsequent report, or the adverse information was received within three months prior to the date the subsequent report is furnished.

Requirements For Uses Of Consumer Reports: The insurance company is a user of consumer reports and is subject to certain rules found in the Fair Credit Reporting Agency and related legislation. Under these rules, if adverse actions are taken on the basis of information found in consumer reports, the insurer must:

- Provide to the consumer oral, written, or electronic notice of the adverse action
- Provide to the consumer orally, in writing or electronically the name, address and phone number of the consumer reporting agency that furnished the report along with a statement that the consumer reporting agency is unable to provide the consumer with the specific reasons the adverse action was taken
- Provide to the consumer oral, written or electronic notice of the consumer's rights to obtain a
- free copy of the report and to dispute the accuracy or completeness of information

Duties of Users Making Insurance Solicitations On The Basis of Information Contained in Consumer Files: Anyone who uses a consumer report in connection with an insurance transaction not initiated by the consumer and that is a "firm offer of insurance" must include with the solicitation:

- A written statement that information in the consumer report was used in connection with the transaction, that the consumer received the offer of insurance because the consumer satisfies the criteria of insurability for the offer;
- A statement that, if applicable, the insurance may not be extended if the consumer does not meet the criteria of insurability; and

- A statement that the consumer has the right to prohibit information contained in the consumer's file with any consumer reporting agency from being used in any credit or insurance transaction not initiated by the consumer.

The person who makes an offer of insurance based on a consumer report must also maintain on file the criteria used to select the consumer to receive the offer, all criteria bearing on credit worthiness or insurability that are used to select consumers for the offer, and any requirement for the furnishing of collateral as a condition of insurability for three years after the offer was made.

Site Inspections

Another valuable tool in the underwriting process is a site inspection. Site inspections are often used in commercial insurance, and may also be used in homeowners insurance underwriting. Site inspections involve inspecting buildings on the insured premises and noting what construction materials have been used, what safety devices, such as sprinkler systems or fire doors, are in place, the overall condition and upkeep of the property, whether there are any hazardous conditions present, and what type of personal property exists. Inspection of the premises may be done as part of a risk management process.

Commercial property and casualty insurers often include loss control or risk management in the underwriting process. The agent or risk management personnel employed by the insurance company may be responsible to conduct a thorough review of the business operations before insurance is issued. There are several different methods that can be used for systematically locating risks that may be reduced through risk management or loss control processes. Insurers often have checklists, called exposure checklists, that are available for use to locate risks in a business.

Another method used to identify risks is through the review of financial statements. Each item on the financial statements is analyzed in terms of risks that arise from that item. A third method is to identify all business activities such as hiring, training, customer services, record keeping and accounting, and to identify the risks related to them. Actual losses can also be reviewed and the risks that led to each loss identified.

A fourth method is to use a flowchart of the businesses operations. A chart perhaps beginning with the receipt of an order through the receipt of payment for delivered goods, that follows the flow of the business from inventory management, processing and packaging of goods, as well as follow-up, may help to discover areas of risk that might be missed if a less thorough analysis were made.

A fifth method is to conduct interviews with managers, supervisors and the actual workers in each business area. Such interviews serve to familiarize the risk or loss control staff with business operations, and add to information found in written documentation about each business function. An inspection of the premises and the operations conducted within is often used to find and verify risks.

Once the inspection and interviewing process is done, the findings are reduced to a report, which is provided to the underwriting department. From the report, the underwriters are able to evaluate risks, and may include requirements, such as requiring certain safety devices to be installed, safety training to occur, and so on, in order to issue a policy.

Insurance Maps

Insurance maps are special maps that include risk information based on location. An insurance map may be designed for use to determine the risk levels related to automobile accidents, automobile theft, property theft, exposure to damage from windstorms or flood, fire, and so on. These maps are used by underwriters to determine the risks associated with the location of property and the territory in which it is used, and therefore to assign the rate appropriate to the risk. Insurance maps may not be used in conjunction with unfair discrimination in redlining, as will be discussed in the next chapter.

Company Records

An insurer will use its own company records as a resource for specific information about the applicant and for general loss statistics related to similar risks. An applicant may have policies in force from the same insurer underwriting the new application. If so, the underwriters will check the information on the existing policies to see how they compare to the information on the current application. The underwriter also wants to determine the total coverage an applicant has with the insurer.

Insurers establish certain maximum coverage levels they will provide for a certain risk or a certain applicant. The company's loss statistics pertaining to the type of risk being underwritten are also used by the underwriters. An insurer must not have too much exposure to any certain risk. If an application represents a potentially high level of exposure for an insurer, the underwriter may look to reinsurance as a way to reduce its own exposure.

Insurance Industry Statistics and Reports

The National Association of Insurance Commissioners and Insurance Services Office, Inc. are two important sources of insurance industry statistics and reports. There are other organizations, such as the Risk and Insurance Management Society, inc., the Inland Marine Underwriters Association, the Health Insurance Association of America, the Insurance Research Council, the National Association of Health Underwriters, and many, many more, that provide research, statistical data and reports for various types of insurance.

Underwriters utilize this data in determining the appropriate rates to charge for applicants. Often this type of data is used when standard rates and manual rates are determined, on both the state and insurance company levels.

Hazards: The underwriting process may involve reviewing many of the resources just identified. The application, reports such as medical reports, consumer reports, credit reports, site inspection reports, and financial statements, and insurance maps, company files and industry statistics are all evaluated.

One of the purposes of the evaluation is to determine whether the application includes indications that there may be certain hazards inherent in the risk to be insured. A hazard is the term used to describe conditions that increase risk. Insurers are generally concerned about three types of hazards: moral hazards, morale hazards and physical hazards.

Moral Hazard: When used by an insurer, the term moral hazard means a condition or conditions that increase the likelihood that an insured or a person in a position to be paid by an insurer will

intentionally cause, overstate or increase a loss. When insurance is used to manage a risk, the insurer takes care to make sure that the amount of the insurance coverage issued is not excessive.

Excessive coverage can contribute to moral hazard. In addition, the insurer may require an applicant to authorize a credit check or other financial review by the insurance company to make sure the applicant is financially healthy. Such financial checks are undertaken to reduce the likelihood that the insurer issues a policy to someone likely to falsify a claim due to financial pressures.

Morale Hazard: A morale hazard is a condition or conditions that increase the likelihood that the attitude of the insured or a person who will be paid by the insurer will cause a loss. For example, once an item or operation is insured, it is possible that its owner will be less prudent concerning it. For this reason, insurers require safeguards in order to insure certain types of property or operations.

A property insurer may require that sprinklers and smoke alarms are installed in a building. A liability insurer will include a question on an application asking if required continuing education hours are maintained. A crime insurer excludes any person who has ever been discovered to have committed a dishonest act from Employee Dishonesty coverage. All these actions are attempts to reduce morale hazards.

Physical Hazard: A physical hazard is a condition or conditions of property, people, or operations that can increase loss. For example, a construction site that allows access to structurally incomplete and unsound buildings increases the possibility that someone who wanders onto the site will be harmed. Insurers are interested in eliminating as many applicable physical hazards as possible prior to insuring a property, a person, or an operation.

Underwriting Decision: Once all the factors are weighed, an underwriting decision is made. The application will either be accepted as a standard risk, a substandard risk, a preferred risk, or will be rejected. Any application that is accepted may include underwriting requirements that must be fulfilled in order for the insurance to apply.

The Role of the Agent in the Underwriting Process

The agent is crucial in the underwriting process. Agents are often referred to as field underwriters, or even simply as underwriters. This is because they gather underwriting information, evaluate risk, often do a preliminary assignment of premium, may authorize preliminary coverage, and may reject applicants on behalf of the insurer. During the underwriting process, the agent is often responsible to gather additional documentation and information to assist the home office underwriting team.

Suitability

An important part of the agent's function in underwriting is determining a suitable financial product for the client. Agents involved in offering life insurance and health insurance products are most affected by the requirements and processes involved in suggesting suitable products.

Many elements are included in determining a client's suitability. These include the age of the client, the tax status of the client, what type of investments the client already owns, the investment objectives of the client and the net worth and overall financial health of the client.

Determining Client Needs

Often the insurance company the agent represents provides procedures and forms to aid in determining a client's needs. Depending upon the types of products the agent offers, the needs analysis or fact-finding process may be relatively simple, or it may be very detailed.

Basic Information: The first part of a needs analysis generally focuses on basic information about the client. The agent will ask for the client's full name, address, occupation, marital status, number and age of minor children, and age of the client, for example. This basic information can help the agent begin to see certain potential needs of the customer.

For example, the marital status of a client may indicate a need to protect loved ones from financial loss. The age of a client can indicate that a client is nearing retirement or at an age when long-term care planning is prudent. The occupation of a client may indicate that he is likely covered by a healthy benefits plan or they he may need full or supplemental coverage. However, the agent needs more information before the agent may make any judgments about potential product needs.

Financial Information: After basic information is gathered from the client, the agent must ask for financial information. Sometimes a client is hesitant to give this information to the agent. If so, the agent may explain that client information is held confidentially and that the agent has a responsibility to the client to understand his or her financial situation in order to give the best advice possible. If a client absolutely will not provide financial information, generally the agent should explain to the client that the agent will have to suspend the interview until such time as the client is willing to provide this information.

Trying to assist a client with a life insurance product without knowledge of the client's financial situation can compromise the agent's fiduciary responsibilities to the client. Generally, the agent will need to know the client's net worth. The agent may ask for an item by- item list of the clients' assets and liabilities, or may just ask for a net worth figure from the client. The agent will also ask for the client's monthly income earned from his or her occupation, and the amount of income the client receives from any other source. Another critical piece of financial information is the tax status of the client. The agent will generally find out whether the client is in the 15%, 28%, 36% or higher tax bracket.

Sample Needs Assessment Questionnaire

I. Personal Information

1. Customer Name
2. Customer Address
3. Customer Phone Number Day: Evenings:
4. Customer Birth Date
5. Customer Occupation
6. Customer Marital Status
7. Number and Age Of Dependent Children Living At Home

II. Financial Information

1. Estimated Net Worth (not including primary residence)
2. Value of Primary Residence

3. Monthly Income from Employment
4. Monthly Income from Retirement Plans (Identify Each Source and Amount)
5. Other Income: Income Amount and Source
6. Marginal Tax Bracket

III. Current Savings and Insurance

1. Mutual Funds: Fund Company, Objective, Amount
2. Bank Certificates of Deposit: Maturity, Interest Rate and Amount
3. Life Insurance In Force: Company, Type of Policy, Face Value and Cash Value
4. Annuities in force: Company, Type, Accumulated Value and Yield
5. Individual Stocks: Company and Amount
6. Individual Bonds: Type and Amount
7. Other Investments (e.g., real estate): Type and Value
8. Investments previously held but now liquidated: Type, when held, why liquidated

IV. Risk Tolerance

1. Able to tolerate significant degree of fluctuation in return for opportunity for high return
2. Able to tolerate some fluctuation of principal in return for opportunity for moderate return
3. Conservation of principal is primary consideration

V. Financial Plans

1. Retirement Savings: Type of plan, how long has it been in existence, value, amount and frequency of current contributions, satisfaction level, concerns and questions
2. Estate planning: Will? Living Trust? Testamentary Trusts? Key objectives of these tools, satisfaction level, concerns and questions

VI. Goals

1. Short-term (1-5 year): Financial goals, amount needed.
2. Intermediate term (5-10 year): Financial goals, amount needed.
3. Long-term (10+): Financial goals, amount needed

Current Investments: A third area that the agent will explore is that of the current investments and financial plans of the client. The agent will ask for an inventory of the mutual funds, certificates of deposit, insurance products, individual stocks and bonds, and any other financial products the customer owns.

If the agent finds that the client owns any life insurance products, it is important that the agent follow replacement procedures if the agent determines that a different life insurance plan should be suggested. The agent will also ask if there were investments the client previously owned but are currently liquidated. The agent should ask if the client was dissatisfied with these liquidated products, and if so, why?

Finding out what type of products a client uses or has used helps the agent to understand the financial experience of the client and the types of products the client likes and does not like. Related to discovering the types of financial products a client currently owns and has owned is determining the risk tolerance of a client.

The agent will generally ask the client a question such as: Which is more important to you, Mr. Client, to earn a high return, or to be sure that you never lose a nickel of the money you invest even if you earn a low return? Or, Are you cautious, or a risk-taker? Sometimes, a client may answer such questions in a manner that seems contrary to the information gathered by the agent.

For example, a client may say that higher return is more important than conserving principal, but have all his or her money in bank certificates of deposit and money market funds. The agent must take into consideration the kind of products the client has invested in, and not just what the client says when trying to determine the risk tolerance of a client. Perhaps with more information a conservative client will be ready to invest in products with a higher opportunity for growth than a bank CD, but the agent must proceed carefully before suggesting a higher risk product if a client's history shows that the client has purchased solely conservative, non-variable products.

Current Plans: The agent will then often proceed to asking questions about the kind of financial planning the client has undertaken so far. For example, the agent will ask about retirement plans, estate planning, whether a will is in place, and so on.

Goals: Another area of questioning involves the client's goals, both short-term and longterm. The agent generally will ask whether the client has goals such as saving for college educations, whether the amount of retirement savings so far will meet the client's retirement income needs, or whether the client is working toward getting out of debt or paying off a mortgage.

The agent will also ask about shorter-term financial goals such as going on a vacation, purchasing a home, renovating a home, or purchasing a new car or recreational vehicle. Besides discussing goals, the agent will ask whether the client believes he or she will be experiencing any major changes in his or her life in the near future, such as children getting married, an elderly parent coming to live at the client's home, or the client's own marriage or remarriage.

Providing Product Suggestions

Once the agent has completed the fact-finding process with the client, the agent may be ready to discuss specific products and plans that may meet the client's needs. Or, the agent may want to spend time analyzing the information gleaned from the discussion with the client, and meet with the client in a few days or in the next week to discuss the agent's recommendations. Whenever the agent begins to discuss product and plan options with the client, the agent has a responsibility to provide clear and accurate information about the programs discussed.

It is important for the agent to explain both the risks and benefits of any product or plan offered to the client. Depending upon what product the agent is offering or in what environment the agent works within, the agent may be required to provide specific disclosures to the client regarding the product.

If an agent sells to customers of a bank, the agent is generally required to provide a disclosure to the client stating that insurance products are not FDIC insured. If the agent is offering a variable product, the agent may be required to provide a disclosure stating that returns on the product are not guaranteed. If the agent is offering long-term care insurance, the agent may have to provide a disclosure regarding the insured's ability to exercise of certain rights under the policy, or regarding certain tax information such as that related to qualified and non-qualified long-term care contracts.

Documentation

Whether or not the client actually purchases the product offered, the agent should keep a detailed record of the information gathered from meetings with the client, and the documentation, brochures and other information shared with the client about the product. Copies of signed disclosures, the application, the fact-finding document, and any other customer-related forms, should be kept on file by the agent. Such a file will not only help the agent should there ever be a question about the suitability of the agent's recommendations, but will also assist the agent in his or her ongoing relationship with the client.

Model Life Insurance and Annuities Suitability Act and Regulation

The NAIC has developed both a Life Insurance and Annuities Suitability Model Regulation and a Life Insurance and Annuities Suitability Model Act. Under these models, rules have been created governing recommendations by agents to consumers regarding fixed life insurance and annuity products. The regulations do not generally apply to:

- Registered contracts
- Long-term care insurance products
- Products sold to sophisticated purchasers
- Policies or contracts that fund employee pension or welfare benefit plans, 401(a), 401 (k) or 403(b), 414, 457 plans, or nonqualified deferred compensation plans
- Group life insurance or annuity products that are not directly solicited by an insurance producer
- Open-end credit life insurance, and group life insurance
- Annuities used to fund prepaid funeral contracts

According to the model regulations, insurers must adopt guidelines and procedures for their insurance producers regarding making suitable recommendations. Under the regulations, a suitable recommendation is a recommendation for the purchase of a life insurance or annuity product that assists the consumer in meeting that consumer's insurable need or financial objective. The insurer must:

- Inform insurance producers of the requirements in the model act and regulations
- Develop procedures regarding the information that must be in from the consumer before making recommendations to that consumer
- Create and maintain a system to determine whether insurance producer practices are in compliance with guidelines and procedures in the model act. Systems an insurer might use include consumer surveys, interviews, confirmation letters and internal monitoring programs
- Provide a system for dealing with noncompliance

The insurer must also create guidelines and procedures, along with data collection processes to collect relevant information regarding the customer's insurance needs and financial objectives. Data collection tools may include customer information forms, product applications and other fact-finding tools. The insurer must also provide training and materials to help agents analyze customer's needs and objectives.

Under the model act and regulation, agents also have important responsibilities. Agents must make suitable recommendations. They may use their discretion to determine what information is relevant for making specific recommendations regarding an insurance transaction. By keeping a record of the information gathered and processes used to comply with the act, agents and insurance companies may demonstrate that they have made a suitable recommendation. Each state that adopts the model act and regulations may have different requirements regarding the number of years that these records must be kept.

Taking the Application: After the agent has recommended a suitable product, the agent is responsible to take the application. It is critical that the agent ensure that the application is as accurate and complete as possible. Almost every piece of information on the application is used to get a fair and accurate picture of the risk to be ensured. The agent has a responsibility to the insurer to faithfully represent the applicant on the application, and the applicant also must provide accurate information to the agent.

Screening Risk: The agent must screen out unacceptable risks for the insurer. The agent may determine that insurable interest is not present, or that an applicant does not meet minimum underwriting standards. In some cases, the agent must inform the applicant that the insurer will not be able to write a policy for that applicant. Or, the agent may try to work with the applicant to determine if there is another method of covering the risk that will meet insurable interest requirements and minimum underwriting requirements.

This may mean restructuring the ownership of a life insurance contract, or writing a policy with lower policy limits than the applicant had hoped, for example. Sometimes cases may be written on a substandard basis that may have been rejected if the agent is able to provide sufficient documentation to the underwriter that adequately explains the reasons behind circumstances that normally would have caused a rejection.

For example, a business that had significant losses through theft may have installed new security systems. The agent writing an application for such a business should submit documentation about the new system so that the underwriters are able to determine if such a system is likely to reduce future losses.

Risk Management and Loss Control: When certain types of insurance are applied for, the agent is responsible to act as a risk manager or loss control manager on behalf of the insurer. This was touched on briefly earlier as it applied to site inspection reports. Particularly in commercial property and casualty insurance, as well as in Workers Compensation and other forms of employer liability insurance, risk management and loss control are critical components of the insurance process.

The agent may have a significant role in this area. The risk management process has the objective of reducing loss. Loss is reduced by identifying risks, evaluating them for frequency, severity and type, determining the best risk response, implementing the response, monitoring the results and making changes as necessary.

Identifying Risks: There are several different methods that can be used for systematically locating risks. Insurers often have checklists available for agents and clients which can be used to locate risks in a business. Another method used to identify risks is through the review of financial statements. Each item on the financial statements is analyzed in terms of risks which arise from that item. A third method is to identify all business activities such as hiring, training, customer services, record keeping

and accounting, and to identify the risks related to them. Actual losses can also be reviewed and the risks which led to each loss identified.

Evaluation of Risks: Each identified risk must be analyzed for its potential frequency and severity. Frequency refers to the number of times a loss is likely to occur, and severity to the amount of financial loss that is likely to come from each loss. A loss which is likely to be infrequent and small is less important to a business than one which may be infrequent and large, and even less important than a loss which may be both frequent and large.

After reviewing each risk based on loss frequency and severity, the risks with the potential for the most serious impact on the business can be given a higher priority. Each risk from the highest to lowest priority are then subject to the processes of determining and implementing a response.

Risk Response: Risks can generally be responded to in five ways: avoiding, preventing, retaining, reducing and transferring.

Avoiding Risk: A business may want to avoid a risk because its potential for financially ruining the company is high. For example, new medical studies may indicate that a certain procedure has some serious negative health consequences. A doctor may decide to immediately stop performing that procedure, and thereby avoid the risk of harming a patient because of it from that point forward.

An accountant may believe others are in error by interpreting a tax regulation in a manner he feels will not be upheld by the IRS, so he decides to provide more conservative advice. As a fiduciary, the accountant may even decide to refer customers affected by the regulation to an accountant who specializes in that area. Avoiding risk may be an appropriate response for high-risk circumstances such as these.

Preventing Risk: Action can be taken to prevent some risks. For example, the risk that someone will fall through rotting boards on the steps to a building can be prevented by fixing the steps. The risk of shortage may be prevented by inventory control procedures. The risk of spreading germs or disease through the use of unsanitary medical tools can be prevented by using new, disposable tools for each patient.

Retaining Risk: Some risks are retained. They may be retained because the loss exposure is small, there is no way to transfer or reduce the risk, or because the risk was not identified. In some cases, risk is partially retained. Purchasing insurance with a deductible results in the partial retention of risk.

Reducing Risk: Reduction of risk occurs when steps are taken to minimize loss. The reduction of risk may be accomplished several ways. Safety procedures may be implemented, disclosures and warranties may be provided to customers, employees may be trained not to answer certain questions but rather to refer "them to specialists within the firm, contract language may be rewritten to reduce ambiguity, etc.

Transferring Risk: Risks may be transferred. They may be transferred through contracts, or through the purchase of insurance. Risk is transferred in contracts such as automobile and apartment rental agreements, construction contracts or through a loan agreement that requires a guarantor to assume the risk should the borrower default on the loan.

When a business changes hands, liabilities of the business may be transferred through contract to the new business owner. Risk is transferred from the insured to the insurer under an insurance

contract. Insurance is often the primary mechanism used to transfer risk. Risks are not always responded to in just one way. A business owner may put into place procedures to reduce risk and purchase insurance on the risk as well.

Insurers often encourage loss reduction and prevention techniques and will reduce premium in some circumstances if loss reduction steps are taken. Or, a risk may be transferred in part through a contract and the remaining exposure transferred through the purchase of insurance. For example, a renter may be contractually liable for damage to a home rented, but the owner will generally carry property insurance on the dwelling as well.

Implementation and Monitoring of Risk Responses

After risks have been identified and evaluated and an appropriate risk response has been determined, the response must be implemented. Steps to do so should be documented and monitored. Once the appropriate responses have been implemented, the process is not over. Risks need to be evaluated on a regular basis. Businesses tend to change over time - new services are offered, new staff is hired, new locations are purchased. Each change can bring new loss exposures.

The insurance agent can assist a business or individual in the ongoing monitoring of risk management and loss control by reviewing the risk management program each year when insurance is to be renewed. By doing so, the agent can make sure the right types and amounts of coverage are offered.

Underwriting Requirements and Risk Management: As a result of the risk management process and the thorough review of the business, its property and operations that occurs during the process, the insurer may require that certain actions are taken in order for insurance to be issued to the business and remain in force.

For example, the insurer may require a safety program to be implemented, require a formal process for reporting injury or loss at the workplace, requires the replacing of unsafe equipment or faulty door and window locks, the installation of a sprinkler system, and so on. The agent is often responsible to assist the applicant in the implementation of such requirements, and to perform an inspection to verify that the underwriting requirements have been fulfilled.

Premium Discounts: The insurer, underwriter and agent may not always require change, but may provide an incentive to a business to make certain changes by offering reduced premiums if such changes are made. For example, if fire doors are installed, the business may qualify for a premium reduction. Some insurers offer complete loss control programs that include a reduced premium for things such as key business personnel attending a certain number of insurer sponsored seminars and training classes regarding loss management and safety.

In the individual lines of insurance, premium discounts are also used to help manage risk and loss. A homeowner with a security system may qualify for a premium discount. Teenagers who have taken formal drivers' education courses may qualify for a lower auto insurance rate than those who have not. The agent can help both the client and the insurer by clearly informing the client of premium discounts for which the client may qualify.

Submitting Documentation: Besides taking the application and participating in the risk management and loss control process, the agent is responsible to submit documentation that supports the

application and is used in the underwriting process. In some cases, the insurer has standards regarding what type of documentation must be submitted with every application of a certain type of insurance.

In order for the application to be processed as quickly as possible, the agent must make sure to obtain and submit this documentation as required. Other documentation may be asked for by the underwriters after the application is submitted. The agent may have the responsibility to coordinate the collection and submission of such documentation. If so, the agent must do so as promptly as possible to make sure that the underwriting process moves forward.

Binding Coverage: Agents may be able to bind coverage once the application is completed. The agent carefully reviews the information provided by the applicant, and if the applicant and application meet certain criteria, the agent may bind coverage until the underwriting process is complete.

Once the underwriting process is complete, coverage will continue in force, or may be denied. Obviously, binding coverage is an important responsibility for the agent, and the agent must be careful to follow insurance company standards in so doing.

Handling Premium: One of the important duties of an agent related to his or her role as field underwriter is the collection and remitting of premium. The NAIC has developed a new model law governing agent trust accounts used to hold insurance premiums. This law may be adopted in many states. It governs the important responsibility of agents to handle client funds properly. The model law applies to all funds received as premiums or return premiums for a policy or binder that are received by any person acting as an insurance producer, agent, sub-agent, managing general agent, broker, solicitor, life agent, licensed general agent, life analyst, surplus land broker, a special lines surplus lines broker, motor club agent, permittee, solicitor or any other representative of an insurer or any other person in the effectuation of an insurance contract.

Under this law, premiums and return premiums that are not made payable to the insurance company, and funds received for soliciting, negotiating, effecting, procuring, renewing, continuing or binding policies, may be placed into the agent's trust account. In addition, any funds that an agent collects from a policyholder or premium finance company and that are to be paid to an insurance company, its agents, or to the agent's employer may also be placed in the trust.

The agent may also place voluntary additional funds in the trust account to use for the advance of premiums, to establish reserves for return premiums or for other contingencies that arise in the business of receiving and transmitting premium. Agents must place the trust account in a recognized financial institution that is subject to the jurisdiction of the courts within the state in which the agent is doing business. In addition, the account must be insured by an entity of the federal government.

The account may be a checking account, a demand account, savings account, or other account with such a financial institution. The account may also be interest bearing. Another option available for a trust account is the use of an investment fund that invests solely in U.S. government bonds, treasury certificates or other obligations backed by the full faith and credit of the United States.

The trust account must be titled as a Premium Fund Trust Account. If the account is interest bearing, the agent may keep the interest from the account. The agent must keep records of the interest and these records may be examined by the insurance commissioner.

Withdrawals from a trust account may be made for the following reasons only:

- Making payment of premium to the insurance company or other producers
- Returning premiums to an insured or other person entitled to them.
- Withdrawing money the agent had placed in the account on a voluntary basis as additional funds.
- Transferring interest to another account
- Transferring actual or average commissions to another account. If it is common practice to transfer average commissions, the agent must keep on file documentation in the form of a letter signed by each principal regarding the percentage of average commission.
- Paying of bank fees and charges
- Moving funds to another trust account in accordance with the model law.

It is prohibited for an agent to treat the funds in a trust account as a personal possession, as collateral for either a personal or business loan, or as a personal asset on a financial statement. The insurance commissioner may have the trust account examined and audited at any time. If an agent violates the provisions of the Agent Trust Accounts Model Law, the agent is considered guilty of theft and is subject to prosecution as prescribed in the laws of the state.

Additional Underwriting Duties: The agent may undertake underwriting duties after a policy is in force. Changes in coverage may require a full or partial underwriting process to be carried out. If new property is acquired, for example, a change in coverage form and documentation about that property may need to be submitted to the underwriters.

Additional premium may need to be collected and a site inspection performed as well. Depending upon the line of insurance to which a change is made, other tasks may need to be performed by the agent in order to effect the change in coverage.

Underwriting Responsibilities Of The Managing General Agent: A managing general agent is a person, firm, association or corporation who manages an insurance business of an insurer and acts as an agent for the insurer. In order to be recognized under the law as a managing general agent, a written contract must exist between the insurer and the managing general agent. Within this contract, important responsibilities of a managing general agent are delineated, including those related to underwriting. Generally, the contract between the managing general agent and the insurance company will include underwriting guidelines that the managing general agent must follow. These include:

- Maximum annual premium volume,
- The basis of rates to be charged,
- The types of risks which may be written,
- Maximum limits of liability,
- Applicable exclusions,
- Territorial limitations, if any,
- Policy cancellation provisions, and
- The maximum policy period.

When a managing general agent's responsibilities include settling claims, a managing general agent must generally follow these rules:

- The managing general agent must report all claims to the insurance company in a timely manner.
- A copy of the claim file must be sent to the insurance company as soon as the insurance company requests or as soon as it is known that the claim has the potential to exceed an amount set by the company, involves a coverage dispute, or exceeds the managing general agent's claim settlement authority.
- The managing general agent must also notify the insurance company of claims that are open for more than six months or are closed.

Many states prohibit the managing general agent from committing an insurer to participate in insurance or reinsurance syndicates, appointing any producers without first making sure that the producer is lawfully licensed to transact the insurance for which he is appointed, or collecting payments from a reinsurer or committing insurer to any claims settlement with the reinsurer without prior approval of the insurance company.

Under insurance law in many states, managing general agents must keep separate records of the business they write from the records of business written by other agents. When a managing general agent acts as a producer, the managing general agent is subject to the same rules, requirements and laws to which any other producer is subject.

Summary

- At the home office of the insurer, the underwriting process begins when an application is received. The first characteristic that is generally evaluated by underwriters is whether or not insurable interest is present.
- Another important factor the underwriters look for in an application is whether a policy issued on an application would result in a valid contract. A contract must include the elements of consideration, the assent of both parties, competent parties and legal purpose in order to be valid.
- The underwriters must also verify that the risk represented by the application is an insurable risk. In order to be an insurable risk the risk must be a pure risk, represent a definable and calculable loss, must not occur to many people simultaneously and not result from intentional loss.
- Once insurable interest, the validity of a contract and the insurability of the risk is established, the underwriters evaluate the basic characteristics of the risk using the application and supporting documentation.
- After the information on the application and supporting documentation is evaluated, the underwriters determine the premium rate to be charged.
- The three major rate determination methods are the judgment rating, manual rating, and merit rating methods. The three types of merit rating are experience merit rating, retrospective merit rating, and scheduled merit rating.
- The presence of a competitive market may impact rate determination and filing requirements.
- Besides determining rates, the underwriters may also specify terms and requirements in order for the insurance to be issued or to remain in force.
- Several resources are used for the underwriting process. The primary resource is the application. Also used are supporting reports, site inspections, insurance maps, insurance company files and industry statistical reports and data.

- One of the purposes of evaluating the applicant's information is to determine whether a moral, morale or physical hazard exists.
- In the life and health insurance arena, the agent is responsible for determining the suitability of insurance products offered to clients. The agent must perform a thorough needs analysis, and should keep documentation regarding the information collected and suggestions made to clients and potential clients.
- The agent has several important duties in the underwriting process. These may include:
 - Taking the application
 - Screening risk
 - Reducing loss through risk management
 - Assisting in the implementation and the verification of underwriting requirements
 - Informing the applicant about applicable premium discounts
 - Submitting accurate and timely information to the insurance company home office
 - Binding coverage

Better Underwriting

Every agent should strive for better underwriting practices. If you continually submit higher-than-normal amounts of applications that are rejected, your income suffers and your clients suffer an emotional downer. Likewise, if you do not follow some basic suitability rules and sell people policies they cannot afford (suitability underwriting), you will experience a higher-than-normal lapse rate among clients who buy now and later drop their policies. You will lose thousands of dollars in trailing commissions, future business that same client may have generated for you and in some states you may be "categorized" as an irresponsible agent leading to fines, penalties and possible loss of license.

Ratings should be of interest to you because it is the system insurers use to "price" policies. Why should you be concerned about premium stability after you have sold a policy? Well, for one thing, you might be sued for not disclosing the possibility that rates for the class of policies you sold can increase. Rate increases are also harmful to your future business. Not only can they cost you a client, but they create the need for new selling requirements be added to the already existing minefield of disclosures you must present to your clients.

Currently NAIC (National Association of Insurance Commissioners) is recommending that some forms of insurance include special disclosures showing your insurer's rate increase history and a signed acknowledgement that rates on his policy can increase in the future. Do you know your company's rate increase history?

Underwriting Problems

Insurers are not always the "victim" in the underwriting process, sometimes they are the problem. Years ago, for example, insurers sometimes approved policies on a post claims underwriting basis (now illegal). The company accepted applicants with little or no real underwriting, but when individuals attempted to file claims, the company engaged in vigorous investigations of the individual's application in an attempt to demonstrate that he or she did not adequately disclose a certain condition. The company would then rescind the policy instead of paying the claim alleging misrepresentation of a condition on the part of the applicant. The company used a vague or confusing questionnaire to aid in this practice. These tactics were only used by a few less than reputable companies and are now prohibited in most states.

There have also been many publicized, criticized and possibly abusive rate increase tactics. In the life industry, for example, insurers continually promise they will not raise premiums due to age or health, but that does not guarantee that the premium will stay the same for the entire class. And, it happens more than you think. Lawsuits have been filed in North Dakota and Florida over premiums that have increased as much as 700%, even though the products were promoted as having level premiums. Granted, this is unusual. Rate increases in the 25% to 50% range are more apt to occur. Either way, rate increases especially hurt your customers, especially those on fixed incomes. Since it may take many years for rates to be raised, people who originally bought on non-fixed incomes typically transition to fixed incomes. They are affected too.

Underwriting Factors You Can't Ignore

A new effort to simplify the application and approval process is underway featuring easier to understand policies and applications, "bundled benefit packages" which give consumers three or four good policy choices and "express" applications where a simple application prequalifies the insured and third party representatives complete the application with the client over the phone.

Even when these policies become widespread you will need to face the fact that between 10% and 30% of your clients will be rejected or rated for higher premiums. Underwriting can be tough on clients and you. But, before you start complaining, you need to understand that a consistent, fair process of evaluating potential insureds is your best guarantee that the company you represent is going to be around long enough to actually pay your client benefits.

Some recent events involving a popular insurers have brought underwriting to the forefront. Rampant sales and minimal underwriting practices have brought companies to the brink of liquidation. High claims have depleted company reserves to less than half required by state regulators. Lawsuits have been filed which may involve agents. Besides the embarrassment and financial exposure of a situation like this, no agent wants to hear that a policy sold to a client is worthless when he really needs it.

How To Improve the Underwriting Process

- Read carefully the General Underwriting Guidelines from your insurance company.
- Obtain a specimen policy and clear-up any questions you have before submitting an application.
- Spend at least 50% more time on applications than you do now. Strive for accuracy and completeness fewer rejections and quicker processing.
- Submit your applications in a timely manner. Most companies consider apps stale dated if submitted after 30 days.
- Allow underwriting time to process applications: you're not the only customer. Underwriters review each application individually - if it fits the required guidelines, it will be issued.
- Know whether or not your state has special rates, disclosures forms, etc. Use the proper paperwork, especially if you work in more than one state.
- Provide underwriters as much information on the prospect as possible. You are legally bound to make personal observations about premises, client mobility, living conditions, attitude, on a separate piece of paper. Anything less could result in an insurer claim against you for breach

of duty. Anyway, why would you waste your time trying to get an obviously unqualified individual approved?

- If a paramed exam or inspection has been scheduled and the confirmation number has been recorded, make sure you put it on the application before submitting the policy for approval.
- If an Attending Physician Statement (APS) is necessary, get the name of the applicant's personal physician who has the insured's medical records. Call the physician's office and ask how much the fee for an APS is and include this information with the application. Sometimes, the physician's fee is more than the check sent by the insurance company. A delay to send more money can slow the entire process.
- Make sure all sections and questions on the application are completed.
- Don't ask for benefits or riders that are not available for the plan selected.
- Be aware of issues limits.
- While individuals with certain controllable conditions or properties might not qualify for the best rates at a top-tier company, an agent who knows the market may still be able to write a policy at standard rates with a top-notch company. Also, there is nothing wrong with calling underwriters and making a case for a client.

Are Insurers Doing Their Job?

Make sure that minimum sales requirements are being met:

- Applications should contain clear, unambiguous, short questions designed to ascertain the health condition of the applicant. Questions shall be limited to yes or no answers. If a question asks for the name of a prescribed medication or prescribing physician, then any mistake or omission shall not be used as a basis for denial of a claim or rescission of a policy or certificate.
- The following warning should always be printed in a conspicuous place on the application: "Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."
- If an insurer does not complete underwriting and resolve all reasonable questions arising from the information submitted with an application before issuing the policy, then the insurer may only deny coverage for a valid claim based on convincing evidence of fraud or material misrepresentation.
- A copy of the complete application should be delivered to the insured at the time of delivery of the policy or certificate.

Your state may also go beyond these requirements and need a checklist of required documents and disclosures such as outline of coverage, receipt of a shoppers guide, a suitability worksheet, replacement policy guidelines and/or specific terminology concerning preexisting conditions.

How else can you help your clients?

Stay abreast of the news. Watch your company ratings and their reserves. Inform clients of any changes and discuss the need to move, if possible, and when necessary.

Of course, most states have state guaranty funds that can help preserve your clients coverage. However, the guaranty systems are a last resort system with limitations. Further, most states do not permit agents to use state guaranty fund information as an incentive to buy any form of insurance.