Article from:

Small Talk Newsletter

May 2001 – Issue No. 17

Small Policies = Big Controversy

by Jack Ladley

Editor's Note: This article is reprinted with permission from National Underwriter. (Small Policies = Big Controversy), March 26th Vol.105, No.13, National Underwriter Life and Health Edition.

As of mid-April, the 23-member SFAWG (small face amount working group) of the NAIC continues to discuss this issue. Action may occur at the summer NAIC meeting at the earliest. Disclosure requirements seem to be the most likely outcome. However, the result could be influenced by two studies that are currently underway, one by the Academy and one by Harvard professor Michael Porter. These studies will focus on profitability and market competition. It appears that, by using composite data, neither study may meet regulators' needs for information on outliers — those companies whose products and practices who likely would be the prime target of any regulations. One area of ongoing concern is situations where premiums exceed face amounts, even by multiples, over short periods of time (such as 10 years). Some skepticism about the value of more disclosure and the likelihood that new regulations will actually be promulgated does exist among regulators.

Life insurers are coming under regulatory scrutiny as life insurance policies with small face amounts stir up a giant-sized dispute.

Small-face amount policies (SFAPs), a product sold in various forms by some sectors of the life industry for decades, have become a giant-sized problem for life insurers in recent months. Regulators have voiced strong concern about how such policies are sold and priced, as well as their overall economic value to consumers.

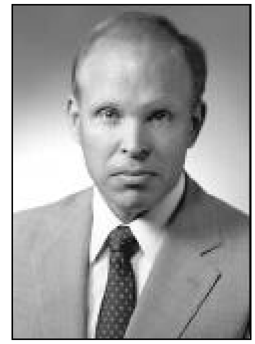
A working group of the National Association of Insurance Commissioners has held hearings on this issue that have attracted large audiences and generated a great deal of insurer activity. The working group has challenged the industry to provide solutions to the perceived problem by June 2001, although it is not yet clear exactly what the problems are to be solved and for which segments of the SFAP business. It remains unclear what size policy qualifies as a "small" face amount.

Adding further fuel to the controversy, more than two-dozen lawsuits have been filed against insurers — generally home service/industrial writers. A key issue cited in these suits is the fact that after a number of years, total premiums paid can exceed the death benefit for some insureds. At least one well-known insurer has acknowledged the existence of this problem and has attempted to remedy it.

Somewhat surprised by the scope of the regulators' inquiries, the industry is scurrying to provide data and suggestions for addressing these concerns. Many in the industry do not believe there is a SFAP problem, at least in their specific segment. And if a problem does exist, it is doubtful that relevant data can be gathered and remedies devised in the short timeframes established. The December resignation of NAIC President George Nichols of Kentucky, who had been the principal proponent of action at the regulatory level, further clouds the picture.

Who is Affected?

The scope of the problem is potentially enormous. SFAPs exist in a number of market segments, each of which has both in-force policies, many of which sold decades ago under different economic circumstances, and more recently sold and priced business. More than 60 million SFAPs in force and at least four million policies sold each year could be affected.



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Generally, these policies are regarded as variations on whole life coverage and have face amounts under $25,000, although regulatory attention primarily has been focused on even smaller policies, with face amounts ranging from only a few hundred dollars to a maximum of $5,000. A model home service act under discussion calls for a $15,000 cutoff, but suggests that the amount be left flexible.

The insurers affected by any SFAP controversy are commonly thought of as smaller industrial and debit insurers. However, many of the largest life insurers have significant SFAP exposure from sizable, older blocks of home service in force and from newer blocks of direct response business. This issue thus crosses all industry demographic boundaries. Some of the business segments that have heavy SFAP in-force or sales include:

- **Home service,** including industrial insurance and debit ordinary, whether or not premiums are collected in the home. There are probably more than 40 million policies in force in this segment, with average face amounts under $5,000 for debit ordinary and under $1,000 for industrial.

- **Fraternal policies,** approximately 75% of which have face amounts under $15,000.

- **SFAPs sold by individual ordinary agents and brokers.** Over a million such policies are sold annually, although the number is declining, and there are likely tens of millions in force.

- **Direct response,** including juvenile policies sold to non-seniors, and guaranteed and simplified-issue whole life (usually on graded benefit forms) sold to an estimated one-million-plus seniors every year.

- **Pre-need,** including policies sold in connection with funeral planning. Many forms are possible, but the most common sales approach involves funeral directors, with single — or limited-premium-products that use virtually no underwriting. Approximately 300,000 such policies are sold each year, and there are over 1.5 million in force.

Of these segments, home service has received the most regulatory attention in the past and continues to draw the greatest interest of regulators and plaintiff law firms. In general, home service has the oldest and largest block of in-force business to cope with and some of the very smallest policies, but the volume of sales is probably not as great as the volume of sales in the other segments. There is also significant overlap among these segments, making it difficult to draw sharp distinctions between them.

Regulators have not yet determined which SFAP segments to focus on. In the heavily attended hearings that have taken place so far, representatives from various interest groups have assumed the task of educating regulators on the marketing, product design, customer demographics, and other attributes of the business sold by each segment. The National Alliance of Life Companies, the National Fraternal Congress, and subgroups representing direct response and pre-need companies have all been represented.

Thus far, there has been little or no internecine warfare, but what happens if rulemaking occurs may be a different matter, if different segments move for exclusion or special exemptions.

Defining the Problem

The primary concern that has surfaced among regulators so far is that after a number of years, the total premiums paid on these policies can exceed the face amount — in rare cases, by sizable amounts, even multiples. The regulators, at least initially, seem to have adopted a layman's view — how can this occur, and how can it be explained rationally to inquiring insureds?

But while this has galvanized regulatory concern, it is not the only issue that seems to be emerging. Other questions are being asked (see sidebar).

These issues have surfaced in regulators' questioning of industry representatives. Regulators, in effect, have generated a complex matrix of concerns with both market segment and issue dimensions, neither of which is well defined at this point. This has caused industry representatives to scramble to gather relevant data, and also to guess as to what course these initiatives might take next. Surveys and studies abound. An atmosphere of pressure seems to be evolving, since the issues are both broad in scope and fuzzy, and data from the various segments are fragmented.

The industry, for its part, concedes that, actuarially and financially, it is possible for SFAP premiums to exceed the death benefit in some cases, but notes that this is a necessary implication of the pooling-of-risks principle. This cost/benefit relationship is known to have existed for many decades and is not generally seen as a problem. It does not appear that this type of argument will win the day, however.

The industry has provided a wealth of information demonstrating that reasonable payouts, competitive rates, and normal corporate rates of return exist in these segments. A long list of arguments against any special treatment of SFAP has been developed (see sidebar on page 14). Many are quite compelling and logical, but, like the actuarial demonstrations, may not be sufficient to satisfy regulators.

Potential Solutions

Thus far, the regulators seem to favor some sort of disclosure, and this is probably the best of a number of possible solutions for the industry. As usual, the devil is in the details, and the implications of disclosure will depend on the form it takes. Whether the disclosure requirements will be based on provisions in the home service model act has not been determined.

From the industry's perspective, the downside to disclosure is that it acknowledges the existence of a problem that, in the opinion of many, really does not exist. Also, disclosure would have an impact on training, risk classification, and other costly processes. And it may unnecessarily complicate the sales process, resulting in lost sales rather than well-informed sales.

Other proposed "solutions" include making such policies paid up, restructuring them into UL-type contracts, setting minimum sizes, establishing new risk-class standards, altering commission patterns, and changing pricing practices.

Forcing such changes has generally been viewed as beyond the scope of regulators, and it is highly doubtful that a consensus on such changes can be reached by June.

These solutions have other implications as well that are not easily dealt with. For example, changes to inforce and new business product guarantees (premium amount, benefit levels, cash values) could have adverse tax consequences for insureds and perhaps for companies as well. The form and impact of such financial changes would take

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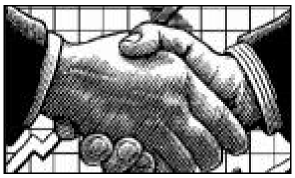
some time to analyze and would have an undesirable financial impact on many companies.

Toward a Compromise



It is encouraging that both sides seem to be heading toward a workable compromise. If the industry can accept the idea that it is hard for the consumer to understand how premiums can exceed benefits, then disclosure seems to be the only viable solution in this tight timeframe. The regulators will have to determine which segments and products should require disclosure. The disclosure requirements themselves must be carefully drafted and evaluated, and in-place requirements and draft guidance must also be considered.

Other initiatives to deal with this issue will take much more time to develop. If regulators want action in a timeframe even close to the June deadline, they probably will have to narrow their scope of inquiry and shorten their list of most troublesome issues. But first, they must ask themselves whether any of the issues raised so far really justify their involvement in aspects of rate regulation.

It is well known that these products, whichever segments and forms come into question, have been received reviewed and approved by regulators for decades. Insurers are therefore understandably somewhat confused by the retroactive aspect of this issue. And they must wonder what issues regulators may raise 10, 20, or 30 years from now on products currently being sold, under different circumstances.

But even if life insurers believe they are justified in their position, their best approach may be to find a solution acceptable to regulators and insureds, and work together in a coordinated fashion to ensure that it is widely implemented. Otherwise, the potential for negative publicity could be substantial, especially coming on the heels of the market conduct problems that continue to hurt the industry's image.

A refusal to compromise would send the wrong message. A positive response from a united industry would pay handsome dividends in terms of public relations, quelling the controversy, and laying to rest any lingering questions about the fairness of products sold to consumers.

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Questions On The Issue

- How can it occur that after a number of years, the total premiums paid on these policies exceed the face amount, and how can this be explained rationally to inquiring insureds?

- How frequently are carriers offering volume discounts for multiple policies or more efficient premium modes?

- Are claims being paid on multiple policies when a claim is filed initially on just one of those policies?

- Why do premiums differ so much, even for the same company and same basic policy form, as has been shown in some comparisons, even if premium differentials usually are linked to differing underwriting that may range from preferred to guaranteed issue?

- Is there a remedy in cases where the death benefit on a policy is now greatly exceeded by the inflating costs of funerals?

- What is the persistency experience on SFAPs in various segments and how can it be improved? What causes a high lapsation rate in some segments?

- Does agent fraud occur with SFAPs and, if so, how can it be prevented?

- Should agents or companies generally be required to provide more information/ disclosure on costs of SFAP and available options?