RECORD OF SOCIETY OF ACTUARIES
1992 VOL. 18 NO. 4B

COMPANIES ON THE EDGE

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- How did they get there?
- Lessons to be learned
- Financial reporting issues faced by actuaries (and others) involved with companies that have failed or are close to statutory insolvency
- Turning it around – strategies for future success

MR. MARK A. DAVIS: Five-and-a-half years ago, First Executive and Executive Life were at the pinnacle of the insurance industry. Also about five-and-a-half years ago, Fred Carr, the chief executive of those organizations, was the keynote speaker at the Society spring meeting in New York City. My how times have changed.

If you would allow me to steal a quote from Shakespeare's *Julius Caesar* and take a little poetic license with it, "We come here not to praise Fred Carr and Executive Life, but to bury them." Fred Carr's keynote speech was entitled, "Risk is Your Enemy." Some of you may remember it. If you don't, I suggest you go back to the *Record* for the 1987 New York meeting and read it once again, for it was quite a good speech. But now that we have the benefit of hindsight we can say, "We're rubber and you're glue, it bounced off us and stuck to you." First Executive and Executive Life have been responsible for much of the turmoil that has gone through the life insurance industry in the past two years. But, they were not responsible for all of the turmoil, and I think we should look at some of the other things that have happened in the last two years.

Fred Buck is the president of First Capital Life and has held that position for about eight years, as far back as when it was called E. F. Hutton Life. Fred will talk about the experiences that First Capital has gone through in the past couple of years. I think he will provide us with some insightful information, and I think we'll all learn quite a bit about what really happened with First Capital. We may think we know what happened, but I'm sure Fred will surprise us with something.

Mel Young will talk about what has happened in our industry as a result of the problems that we have had, and he will discuss what companies can do, and indeed have done, to turn it around. Mel is a principal in the Stamford office of Tillinghast and has been with Tillinghast for eight years. Many of you will remember Mel in his previous position; he was with General Reinsurance for 15 years.

What companies are we talking about when we say *companies on the edge*? So that we'll all be on the same plane, I've grouped some of the more well-known companies as follows:

APPROACHING THE EDGE: Fidelity Mutual?, Mutual of New York?, and Travelers?

AT THE EDGE: First Capital, Monarch Life, and Mutual Benefit.

OVER THE EDGE: Executive Life.

This list is by no means all-inclusive, and the classifications are based on my own opinions and perceptions. I suppose the Equitable of New York could be included somewhere, and so could many smaller, lesser-known companies. But generally speaking, these are the companies that have been featured in the media, if you will, as having some financial problems. I have put question marks next to companies that may be getting nearer to the edge. I would admit that, other than Fidelity Mutual, the other two are speculation on my part, based on what I read in the *National Underwriter* and other publications. So those are some of the companies that we're talking about.

I've developed six broad causes of the financial problems typically encountered by companies on the edge: (1) bad assets, (2) external influences, (3) competitive pressures, (4) capital inadequacy, (5) Ronald Reagan, and (6) company management. These are all fairly obvious, of course, except Ronald Reagan. I will talk about how our former president had a hand in this, as well as the other five causes.

Generally speaking, I think the problems that have occurred in the past few years have been more asset related than liability related. This is kind of a natural outgrowth, if you will, of the changes that have been taking place in the life insurance industry over the past decade or so. Life insurance is much more of an asset-intensive industry now than it used to be. For many companies, it is now a spread game, and that's almost all it is for them. We all know that C-1 problems, credit risks, defaults, etc., often led to liquidity problems. Ultimately, there was a C-3 problem, because policyholders wanted their money and there was no liquid market value or cash flow there to pay it. It turned out to be a bad matching of assets and liabilities. But the mismatch was more of a result from other problems than a cause.

One issue I'd like to raise is, just how appropriate are commercial mortgages and real estate as life insurance company investments? It seems that companies that were heavily into these instruments are now experiencing some serious problems. That doesn't mean that these assets are necessarily inappropriate, but given what's happened in the past few years, certainly it seems that they are very inappropriate at the present time for many companies and situations. Many companies have successfully invested in these types of instruments and have not experienced problems that threaten solvency or financial strength. But, in general, I would say real estate and commercial mortgages are more appropriate for assets backing surplus and less so for reserve liabilities.

I've heard of various situations from time to time where a company believes that its GIC portfolio is perfectly matched with a series of commercial mortgages, many of them bullet or balloon mortgages. And they are perfectly matched until the mortgage balloon day arrives and the GIC must be paid out, and the mortgagees ask if they could refinance or change the terms of the instrument around because they don't really have the money right now to make the bullet or balloon payment. I really don't believe these types of assets should be featured in backing certain reserve liabilities. I also think the problems that have been experienced have highlighted the need to diversify not only by industry but also geographically. It seems that the biggest problems that I've read about occurred where companies had a disproportionate share

of these instruments in the Northeast or on the East Coast, where the real estate markets have been hit the hardest.

Another interesting thing is that these C-1 problems happened during a period of fairly stable, although declining, interest rates. The actuarial profession and the NAIC are now very concerned with cash-flow testing. Cash-flow testing is primarily a C-3 risk-assessment procedure. But the recent problems in the insurance industry are much more C-1 related. This brings into question what provisions in cash-flow testing we should be making for C-1 risk. I've been somewhat of a critic of current practice: we simply make a reduction in yield provision for asset defaults, a few basis points here, a few there, more for triple-B bonds than for triple-A bonds. But we just make a provision and assume we get an average level of defaults every year. This deviates from reality quite a bit, because we do not see an average amount of defaults in most years. In addition, an asset either defaults or it does not. In reality, we don't see the nice clean six basis points knock every year like we do in our cash-flow testing. I'm hoping that this is something the profession can improve on in the coming years and that we actually get into some valuable C-1 testing as part of cash-flow testing.

Many external influences impacted the financial problems in the life insurance industry. I think that collectively what happened was unique. I don't think there was any one factor that caused financial impairment, but rather there was a collection of things that came together and caused some unprecedented things to happen. These external influences were: Drexel/Milken -- junk-bond market collapse; memories of the S&L crisis; economic recession -- regional/national/international; bad publicity (from Executive Life); and, impact of rating-agency downgrades.

A few years ago, the junk-bond market was quite interesting. Some of you may have read the books that are out about First Executive and Drexel Burnham and Milken -- it's fascinating reading. One of the things I learned is that in some cases, Executive Life and a few other insurers were the junk-bond market. It's also interesting that Milken was often on all sides of the deal. When these facts came out, the junk-bond market collapsed, and that really started all of this. I think Fred Buck can explain it better than I can, but let me offer a few comments on what happened in the aftermath of the junk-bond-market collapse.

I also think the memory of the S&L crisis was quite fresh, at least in policyholders' minds, and that influenced their reactions to what they were seeing and hearing. The bad publicity was unbelievable. I personally believe that, if it weren't for the problems at First Executive, some of the other troubled companies would not have faced the financial crisis that impaired them. I do not believe they would have had the runs that they did. There was a policyholder run at First Capital; there was a policyholder run at Mutual Benefit. If there was no bad publicity coming from Executive Life, then I think those runs on the bank would not have occurred.

It was interesting to see, still speaking about bad publicity, how journalists and financial columnists reported the takeover of Mutual Benefit Life. In my newspaper, a prominent financial columnist reported that Mutual Benefit was seized by New Jersey regulators. The way I remember it was the company asked to be taken into supervision. I think there's a very distinguishable difference there. The company seemed to act very responsibly under the circumstances, but in the paper you read how it was

seized, like it had been trying to pull a fast one on the New Jersey Insurance Department. That's really not the way it was. Policyholders and the public do not normally read the insurance trade press -- they read newspapers. Public reaction was influenced by the misleading use of *seized*, and the connotations implied by that word.

I think we now know that a downgrade from a rating agency can have dire consequences in certain situations. When these problems occurred in mid-1991, the rating agencies became very powerful. I'm not so sure the rating agencies acted responsibly in all cases, because they downgraded some companies merely because of the perception the industry wasn't as healthy as it once was. There were really no fundamental changes at some companies, and they were downgraded anyway. This added more fuel to the fire.

One side note about rating agencies and downgrades -- recently I heard about a single premium deferred annuity (SPDA) that contains a product feature that I'm going to call a rating downgrade bailout. The way this product feature works is that, if a rating-agency downgrade occurs, a bailout window in the product opens up, and policyholders can take their money with no surrender charges assessed. This feature is just asking for trouble! It's inviting a run. Who could have possibly devised such a thing? I think it came up in New York recently, and, of course, the New York Insurance Department disapproved the product filing. But this type of product feature coming to light on the heels of the recent policyholder runs is incredible to me. Perhaps my reaction is reflective of my actuarial specialty -- financial reporting rather than product development.

Next, I think you all know the life insurance game has changed over the past 15 years or so. With increased consumer sophistication and awareness, insurers certainly have become much more competitive in fighting for those savings dollars. We've become more competitive among ourselves, but we've also become more competitive with other financial instruments, especially mutual funds. Consider that even collateralized mortgage obligations (CMOs) are now available for individual investors. So we've had to try a little bit harder to get those savings dollars, and this has led to lower and lower margins. In an effort to try to compete and make a good profit, we've tried to credit higher rates of interest, which led to lower-quality assets, which resulted in more risk. There has also been a slow but sure decline in capital in the life insurance industry. This was not good timing for many companies, because when capital was down, risk was up, and the two of those together lead to risk being undervalued.

Now we come to the cause that I labeled earlier as "Ronald Reagan." I don't think he personally was a cause, but I use his name to describe what I think is a cause often overlooked when examining what went wrong in the life insurance industry. I believe the economic prosperity of the 1980s lulled many in the insurance industry to sleep, creating a false sense of security. I hope that what happened recently has wakened everybody up again. We should all realize that things can change in a big hurry. We shouldn't relax because of economic prosperity; we should still be aware that things can go bad very quickly.

Some people may argue that management or bad management should be the primary factor for many of the problems that occurred. In some cases, I would agree with

that. But, I don't believe the unique sequence of events that took place that caused these problems can be pinned on management in every instance. Many external influences were completely outside the realm of management. I don't think we can just put the blame on management.

Let's move now to what I call actuarial analysis. Let me pose a few rhetorical questions. Did actuaries cause or fail to prevent these problems? Could the appointed-actuary concept and cash-flow testing have prevented these problems? Are we guilty of not assuming responsibility? I think the answer is no. I can't blame this on actuaries. I think it's unfortunate that, in some cases perhaps, actuaries weren't in better positions in companies to perhaps make management more aware of the financial impact if things went bad, but I don't think in general we can just pin this on the actuarial profession. What can we do about this in the future as a profession? How can we help to prevent these types of problems from recurring? The main thing I came up with is, we as a profession could help our managements formulate and implement a comprehensive asset/liability management process. I think we are uniquely qualified to bring together senior management, the investment department, and the marketing department and force them to communicate. As a consultant, I see what happens in many companies. In some companies out there, even now, the investment people and actuaries have never spoken to each other. They just go their own ways.

One thing I've observed about investments at an insurance company is that the investment officer is usually more comfortable with certain assets or markets than others. The reason for this is that he or she has been working in that particular area for maybe an entire career. So in the absence of specific guidelines, if the investment manager is out of the commercial-mortgage school, the company is going to buy commercial mortgages. I think actuaries need to get together with senior management and investment officers and develop comprehensive strategies for management of the investments. This happens very regularly in some companies, but it's a totally foreign concept in far too many other companies. I believe the companies where this is a totally foreign concept are the ones most at risk.

What lessons have we learned from the events of the past two years? We should have learned a few. Was this just a temporary one-time happening, or is it something more permanent? The specifics of the situation with Executive Life, rating-agency downgrades, and the S&L crisis tend to make me believe that this was a temporary situation coupled with good timing or bad timing, depending on your point of view. But I think the effect on the industry is more permanent. Mel Young will talk about what changes have come about because of these problems and how the life insurance industry can walk down a more stable path in the future.

Another thing that I've come to realize, and, I hope we all have, is that the life insurance industry is totally lost without public trust and confidence. If the consuming public loses trust in our business and our promises to pay benefits many years into the future, the future of our industry would be bleak. The actuarial profession must continue to become more involved in ensuring the financial health of our companies. The emphasis given to broadening our skills should help actuaries strive for more senior positions in company management. We should help the companies address

the types of problems I've discussed and develop successful strategies to combat them. Fred Carr was right – risk is your enemy.

MR. FRED A. BUCK: I'm glad that Travelers and Mutual Benefit have had some publicity, because for a while, to be in trouble you had to be domiciled in California and have a CEO. This was a serious problem.

Let me tell you what I'm not going to talk about. I will not talk about C-1, C-2, C-3, and C-4. Even though I'm an FSA, I probably forgot what those things are, and I would probably embarrass myself. Also, I want to thank Mark for not pinning conservatorship totally on management and for softening his comments a little bit about actuaries and management and what difference that would have made. Candidly, in my case, it didn't make much of a difference.

Several things contributed to the problems at First Capital Life, and it probably started a long time ago. It started when E. F. Hutton bought Life Insurance Company of California, because at that time, we became a wholly-owned subsidiary of a holding company. When you're a wholly-owned subsidiary of a holding company, you really don't have much control over what the holding company does. Our problems started in 1985, when Hutton admitted to multiple counts of mail fraud and check kiting, as well as other wrong doings. I think that was the beginning of the end for E. F. Hutton. One of the things that Hutton did to try to stave off its takeover, or downfall, if you will, was to raise capital. It sold Hutton Life, which was probably the best thing it had to sell at the time. So, on May 17, 1987, we were sold to First Capital Holdings. It's kind of ironic that we were conserved on May 13, 1991; we never even made five years under First Capital Holdings.

In any case, we should have known that this was not going to go well, because three days after the sale was completed, there was a feature article in *Barron's* discussing the head of First Capital Holdings, Mr. Weingarden, and the deal to purchase us. The article discussed the lack of capital, the way that the company was financed, and it generally criticized various aspects of the deal. I think some of those criticisms were well founded, but others were not. One of the big problems was that First Capital Holdings acquired us with massive debt. We were a leveraged buyout (LBO) in every sense of the word. And, when we were purchased, I think we looked at this as sort of three problems: the debt, the debt, and the debt.

To remain competitive and to service the debt, First Capital Life needed to achieve a very large interest-spread relative to its competitors. Therefore, to remain competitive, we were forced into the high-yield bond market. I think that First Capital Holdings had a degree of expertise, if there is such a thing, in the high-yield bond market, and it had a fairly decent high-yield bond portfolio relative to our friends up in Los Angeles. We had very tight constraints on the amount and the type of high-yield bond we would buy.

Anyway, the NAIC used to rate bonds "yes," "no," "no star," "yes," "no," and so forth, and on that basis, 20% of our assets were in high-yield bonds. I thought that was sort of a fallacy among insurance regulators, to have this kind of system. Most people were used to Moody's and Standard & Poor's (S&P). On a Moody's and S&P

basis, we had close to 40% in high-yield bonds. It's much different from the NAIC basis.

Progressing along the road, it was December 1987 when E. F. Hutton collapsed and Shearson purchased E. F. Hutton. One of the first things it wanted to do was try to regain control of the assets, which were resident in First Capital Life. Hutton producers had sold approximately 80% of our business; we had about $3 billion in assets, and 80% of it or so was Hutton's business.

In any case, Shearson bought controlling interest in First Capital Holdings during 1988. And then in 1989, Shearson had to be bailed out by American Express for, again, lack of capital. What all this did for First Capital Life or for Hutton Life was create negative publicity, which we didn't need, and it really originated from our holding company. As Mark pointed out, one of the big drivers of companies on the edge, perhaps driving them over the edge, is publicity.

Also in 1989-90, there was the birth of Martin Weiss and his safety index, and we were one of the 10 worst companies. That was, again, one big shot of negative publicity. Then there were continuing articles in everything from the *Des Moines Register* to the *Los Angeles Times*. This was the kind of thing that we were continuously trying to respond to and people kept questioning us. Despite all this, however, in 1989 we wrote $1.2 billion of premium with Shearson and with our agency system.

Mark already mentioned the Drexel and Milken problems. Obviously, that tainted high-yield bonds even more than they already were, as Drexel collapsed and as Milken became more and more the notorious figure that he ended up being. Mark also mentioned rating downgrades. We were downgraded by A.M. Best from A to A– in June 1990. That had a dramatic impact on our situation. And then, finally, the straw that broke the camel's back was that Executive Life collapsed. Executive Life was taken into conservatorship in April 1991 and that started a significant run at First Capital Life. Also, you may remember that in March 1990, our chairperson, Mr. Weingarden, resigned. We also had to restate 1990 earnings, and they also announced the sale of our universal-life block. Collectively you saw in the papers then a company basically falling apart.

The commissioner of insurance in California, Mr. Garamendi, tried to get capital contributions for us from American Express and Shearson, and he coined the now famous phrase "if membership has its privileges, ownership has its responsibilities." That, unfortunately, didn't shake American Express very much and it decided to ride it out. To give you some numbers, our average weekly surrenders in January 1991 were $17.2 million. In February, surrenders averaged $22 million; in March, $15 million; and in April, $33 million. The first two weeks of May totaled $290.7 million per week. When a run starts, it can leap up rather geometrically.

I don't think this is news, but we also asked for a cease-and-desist order, and the commissioner graciously agreed. On May 10, 1991, we were issued a cease-and-desist order, which enabled us to stop the policyholder run. If you want something to put you to sleep at night, read the court proceedings. You will see that the big bone of contention in our court proceedings was, was the company truly insolvent? The

only problem with the company at the time was a run. Something had to be done to stop the run. In any case, on May 11, right after we received the cease-and-desist order, the creditors of First Capital Holdings put the holding company into involuntary bankruptcy. The commissioner, feeling that he had to preserve the assets of the life company, then conserved the life company to protect it from the bankruptcy proceedings at the holding-company level.

A conservation begins by the commissioner going to court to get the court to issue orders. The orders defined a conservation supervisor, Jerry Reiley, who was the chief of the examination division in California. The orders named three or four conservation managers who were the senior officers of the company. This is very rare. I think California believed the problem resided at the holding company, not at the operating-company level, and so we were fortunate to ride out the storm. In most conservations, the regulators will take over, and they will terminate probably 50% of senior management.

What could we still do? We always paid 100% of death benefits. I know Executive went down to 70%, but we always paid 100% of death benefits and 100% of annuities in the payout stage. Basically, that's it; we would allow nothing else. We wouldn't allow any redirection of premium. We wouldn't allow any decreases. We wouldn't allow any change in or suspension of riders, or anything else. As far as operating the company, everything over $75,000 had to be approved by the conservation supervisor. Other than that, we ran as normal. And since we stopped paying surrenders, there weren't a lot of payments to be made, other than routine payments.

Leading up to conservation, several states had asked us to do monthly financial reporting, which continued after conservation for a month or two, and then, basically, we issued quarterly statements. We had to draft letters and communicate with the policyholders as often as possible. But, if I told you the number of constituencies involved in this, you'll know why we only had maybe a half dozen letters go out to policyholders, because it would take seven weeks just to get one out. Even though we were in conservation, we did have an audited financial statement. One of the good things, and I think everybody here would like this, is that we stopped doing GAAP financial statements. That freed up a lot of time for our actuaries to do other things. We did, however, decrease staff by 50%. We basically cut the staff in half. We had no marketing department, there was no need for it, and no new-business department. A few other areas of the company were also scaled down.

We were in conservation for about a year-and-a-half, maybe a little more. During that time, we probably underwent due diligence at least seven times by seven different companies. And that, as I'm sure all of you can appreciate, is a very time-consuming thing. They always want to talk to the actuary, and they always want to talk to the president. So we spent much of our time showing people our books. And much time was spent doing that during rehabilitation.

We basically started the rehabilitation a week and a half after we went in to conservation, on May 13, 1991. I think that by May 31, we had drafted a rehabilitation plan. I drafted the initial rehabilitation plan; it was two pages long, and it basically consisted of the provisions of the rehabilitation plan that was finally adopted. Now the

rehabilitation plan is 240 pages long, but that's what can happen when you get several lawyers involved in the process.

Anyway, the team that the commissioner basically formed consisted of a deputy commissioner, an investment advisor, actuarial advisors, attorneys from two law firms, a tax advisor, several department-of-insurance personnel, and myself. And believe me, my billing rate was the cheapest of all those people. Conservation is a very expensive process. Everybody is very concerned about what the company is going to do, and every step you take is reviewed by several different people to make sure it's the right step to take. So you have a very bureaucratically intensive process to go through to do much of anything.

The initial negotiations continued with American Express and Shearson. That continued for about eight or nine months, until we finally came up with a basic plan that Shearson and the commissioner would both sign. This plan, as it is in every conservation, is presented to the court, and the court then orders open bidding.

So we put the plan out and we put out bid specifications. We had several interested parties come through, as I said earlier, and conduct due diligence. In the end, we had four bidders: Transamerica, Pacific Mutual, Leucadia National, and Shearson. Leucadia was bidding as a representative of the creditors committee for the holding company. I think one of the main reasons behind the Leucadia bid was to give action to the creditors standing in the court. We had two rounds of bidding, and then the net result at the end of the second round was very close. We asked for a third round of bidding and finally recommended Pacific Mutual.

We evaluated the bids in a few ways. First we evaluated them subjectively, based on certainty, capitalization, policyholder benefits, management, definitiveness, and other considerations. Then the actuarial advisors, Coopers & Lybrand, devised what it called a benefit index. What that essentially measured was the present value of benefits over the life of the plan to the policyholders. This was tested under three lapse scenarios; low, moderate and high; it was tested under two default scenarios for high-yield bonds: low and high; and then it was tested under two tax scenarios: favorable and unfavorable. Pacific Mutual came out in every case the winner, so that is why Pacific Mutual was recommended as the rehabilitator.

The court process was an interesting experience. We recommended Pacific Mutual and you would think the losing bidders would go away. Not in this case; Transamerica really wanted this company badly. And, as a result of that, the court process, which should have taken a day-and-a-half, ended up taking almost two months.

The first thing we had to do was calculate a liquidation value. A liquidation value is somewhat an artificial value, but it's sort of regulated by statute or by pre-existing case law. To calculate liquidation value, you have to assume you sell all assets for cash in four months. Consequently, much of your real estate is worthless. Your high-yield bonds, private placements, those kinds of instruments, are discounted significantly. Other assets, such as recoveries from the guarantee fund, not from premium tax, are wiped out. All the liabilities are calculated on a cash-value basis, rather than on a reserve or account-value basis. You basically calculate all liabilities that you think will be due, eliminating what are called class-6 liabilities, which are your

bills; you don't have to pay them. Then you calculate a ratio called the liquidation value. Ours was 89.6%. What that means is if we liquidated the company, policyholders would receive 89.6 cents on the dollar of their cash value. The reason you have to do this is because the rehabilitation plan must give policyholders more than the liquidation value; otherwise, the rehabilitation gives no value to the policyholders. In that case, you're ordered to liquidate the company.

We provided this information to the court and then went and testified regarding the plan provisions, which I'll get into in a little bit. One of the big issues raised in court was the solvency issue, which was primarily raised by the creditors of the holding company. If you look at all of our quarterly statements, we always had surplus all the way through the conservation. It might be a buck-and-a-half, but we've always had surplus. I think that the solvency issue was critical to the holding company, and that, primarily, was because the creditors of the holding company contended that the policyholders should not benefit extraordinarily at the expense of the creditors of the holding company. Then we spent about a week trying to determine what makes policyholders whole. We determined that if the policyholders received their account value, plus 6.5% interest over the life of the plan, they would then be whole. You'll see that's the way the plan eventually came out.

Coopers & Lybrand then went through the benefit index, which illustrated that Pacific Mutual was the top bidder in every case. We still had this contention all during the court process of whether Transamerica should be allowed to make another bid. That finally all went away. I think Pacific Mutual compromised with both the creditors and Transamerica. On the last day in court, everybody stood up and said they had no more objections, and then the judge approved the plan.

After court approval, you're allowed 30 days to notify the policyholders of what transpired. After that, the policyholders have 60 days to respond; that period ran and finished October 15, 1992. In this case, because of the structure of the plan, which is to form a new insurance company, there are two closings: one is on Friday, October 30, and the other one will occur December 31. The closing on Friday basically stops coverage for all people who have opted out. If you've opted out, you won't be paid any death benefits after Friday. So that was the purpose of that closing. And I'll tell you the results of that in a minute.

What are the plan provisions? Basically, Pacific Mutual guarantees the plan by its full faith and credit. In other words, every provision in this plan is not only backed by Pacific Corinthian and First Capital Life assets, it's also backed by Pacific Mutual's assets. They will form a new company called Pacific Corinthian Life. The new company, by the way, is already formed and is already licensed in about 40 states. We've had tremendous cooperation from the regulators in this regard.

They guarantee that policyholders will get, at a minimum, their account value plus 4% interest over the five-year course of the plan. At the end of the plan, they will merge all the policyholders into Pacific Mutual. Current policyholders will become Pacific Mutual policyholders at the end of the plan.

Pacific Mutual capitalized Pacific Corinthian Life with $50 million. The policyholders could opt out at 90 cents on the dollar for their cash value. If they stayed in, they

will get a credited interest rate, of the earned rate which takes into account capital gains and losses, less 150 basis points. They're allowed to take 10% loans and 10% partial withdrawals. They can annuitize over a period greater than seven years. They're allowed to decrease their face amount by 5% a year. They can surrender once a year on the day before their anniversary, and they will get a percentage of their cash value. The percentages over the five years run 90, 90, 90, 93, 96, and then 100%, so they're made whole at the end of the fifth year.

There's a profit participation at the end of the plan. After Pacific Mutual takes back its $50 million and interest on that $50 million, 90% of the remainder goes to the policyholders to be made whole, as if interest had been credited at 6.5%. After that, whatever money is left is split: 10% to the policyholders and 90% to the creditors. The creditors will, eventually, get something out of this.

As far as management is concerned, Pacific Mutual will give services at cost to Pacific Corinthian. Pacific Mutual agreed to retain 90% of the employees on the closing date, which is December 31, 1992, and it will retain 90% more for at least one year after that. It will not write any new business into Pacific Corinthian.

Another provision of the plan is that they are allowed to make a real estate adjustment. All of our real estate will be revalued and, if necessary, write-downs will be taken right away. We also have special deposits in several states. If we can't get those back, they're allowed to essentially debit the policyholders in that state for those amounts. They will be paying renewal commissions.

There's been, roughly, $450 million of account value that has been opted out. That is about 11%, which was probably lower than anybody really thought it would be. As I said, Pacific Corinthian Life is licensed in 40 states and expects to be licensed in all the necessary states by the end of the year. Right now we're preparing the closing documents for the closing on October 30, 1992. It's been a very long process, a very tedious process, but now it's well on its way, and I think the policyholders will eventually come out whole.

MR. MELVILLE J. YOUNG: Once upon a time, life insurance companies made money the old-fashioned way: dumb luck. Once upon a time, our products made money, although if asked, we could not put our finger on how or from where. Once upon a time, our companies could go into new businesses for reasons only Solomon could understand, at the drop of a new promising agent's hat, and achieve a modicum of success. Once upon a time, we made so much money at most things that we could endure the rampaging recklessness of an occasional charlatan and still prosper. That was then.

Our corrective antacid has to do battle with a diet too rich in charlatans and far too poor in good management. We have lived through a series of highly public financial collapses of insurance companies, reported by a media lacking indepth knowledge and regularly apply simplistic explanations and labels to the causes of these sad events. From a twisted point of view, the quick explanation might be appropriate, because many complex, troubled situations were exacerbated by shallow attempts at the quick fix.

Let's play "Jeopardy." I'll give you the answer and you provide the question. The category is life insurance companies. A company that paid its distribution too much to sell its inadequately priced products, administered policies inefficiently, invested the resulting funds unwisely, and occasionally bought ill-advised reinsurance, thus postponing and exacerbating the inevitable financial calamity.

The name "Jeopardy" is all too appropriate for this game. The problem with the question is there are far too many companies that have been put in jeopardy and thus fit the bill. Although the negative fallout to our highly public failures has caused some overreaction, in general, the response by the industry to the negative publicity has been positive.

What I'd like to do is tell you what I think we've been doing in reaction to some of those problems. I will address six areas: improved expense management; sounder reinsurance practices; increased attention to capital adequacy; pricing methodology improvements; sound financial planning tools; and greater public awareness and sophistication.

The day of the sacrosanct loss leader is done. Those company managements that have been reluctant to make the intellectually pleasing, practically unpleasant decision to divest losing operations have either been forced to do so because of capital constraints or have simply been allowed to by the jumping-on-the-bandwagon syndrome. Examples include: individual disability income: New England, Provident Mutual, Crown, National Life, John Hancock, and General American; group: Allstate, Transamerican Occidental, Mutual Benefit, Central Life, and John Hancock (small group); individual life: Washington National, Sun Life of America, Monarch, and UNUM (close down).

Five years ago, most of these actions wouldn't have happened. Companies are beginning to focus on their core business, which I think is a major positive.

In February, there was *The Wall Street Journal* article entitled, "Streamlining Wave is Sweeping Insurance Companies, Widespread Staff Cuts Are Planned as Industry Braces for Consolidation." What that article didn't address is the number of companies that have been going through their distribution systems in the last several years, paring those inefficient systems and measuring the profitability of individual distributors and distribution systems.

A recent article in *Best's Review* addressed companies that perhaps were going too far. I think that going through this type of operation is important, but doing it right is sometimes more important than doing it. We do have to look at the long-term focus.

There are companies focusing for the first time on the profitability of distribution channels. Some life insurers have been using value-based accounting methodology to compare the expected costs that distributors have to their actual expenses. Some are actually using value-based methodology to make long-term planning decisions on what distribution systems they will emphasize and which distributors they will pare. Also, the resulting intelligence has helped those companies in repricing their products.

There's also recently been a greater use of alternative distribution systems. Many companies have been looking at their unit costs and have been struggling for ways to add units. Some major companies have been making, what are for them, fairly dramatic decisions: either adding brokerage distribution, buying blocks of business, or using other alternative methods of distribution.

Several publicized failures have been blamed on shoddy reinsurance arrangements. Certainly poorly constructed or otherwise inadvisable transactions have occurred. Many of the companies we've talked about have had problems that were blamed on reinsurance transactions. The part that reinsurance has played in most of those collapses has arguably been overstated.

But every industry has its fast-buck artists, and to some degree, there has been a need for additional tools to be available to state regulators. Due to the furor caused by some of the most spectacular insurance failures, some of the tools provided have turned out to be pile drivers, when simple hammers would have sufficed. As a result, those well-managed companies in need of reinsurance will find themselves paying more due to the excesses of a few.

One positive development is that there has been greater attention being paid, by the providers and users of reinsurance, to the soundness of the arrangements and to the financial integrity of the other party. As a result, policyholders' money entrusted to us should be more diligently safeguarded. In general, the reinsurance arrangements that we see are sounder, and the companies being encouraged to grow through reinsurance financing are among the most deserving. We hope what results as greater intelligence is that those who abuse the trust will see fewer opportunities and will seek other industries to exploit.

Being one who has spent most of his career involved in reinsurance, I've seen many situations where reinsurance has been abused, and the regulators have regularly been struggling with that. As I've said, I believe that in some cases, some of the regulatory actions have gone overboard, which will result in increased cost. But one result is that some of the people, whom we won't name, who have abused the trust, won't as easily receive capital through reinsurance in the future.

As a result of increased regulation, rating-agency scrutiny of transactions, and a greater sensitivity to perceptions and image by management, many companies are turning to more traditional forms of reinsurance to meet their risk-sharing and capital needs. The current reinsurance activity, the major direction that reinsurance is going in today, is that we see more and more traditional reinsurance transactions where reinsurers are participating as full partners. That's not to say that all financial reinsurance was badly constructed or did bad things, but we are seeing, because of all the things that have happened, a movement in this direction.

There has been a convergence among the regulator's cry for better tools, management's cry for better, more easily understood information, the actuaries' awakening to the need to study both sides of the balance sheet in tandem, and the rapidly improving available computer technology.

The availability and understanding of this technology has caused a mushrooming in the uses of the technology. As the use of the technology has expanded, the understanding of the businesses in which we function has increased enormously.

The recent NAIC activity that resulted in the proposed risk-based capital formula is a model example of an industry and its regulators working together for the public benefit. If abuse, by the few who tend to abuse, can be prevented, the risk-based capital effort should result in a resounding win for all concerned. Life insurers are already eliminating nonprofitable businesses, more closely examining and managing assets, studying the profitability of products and distribution systems, showing a new awareness of risk-management principles, and improving the tools used to create the understanding of their businesses.

In addition to the growing trend to restructure the liability side of the balance sheet, thus allowing companies to focus on the lines of business they do best, virtually all companies have been actively restructuring their asset portfolios. The rapid improvement of asset/liability management tools has facilitated this activity. Capital has begun to flow into our industry as evidence builds that we are getting our act together. This has been evidenced by several, very dramatic, recent infusions of capital and several more that should be announced soon. I think this is the first time in the recent past that there has been a significant inflow of capital into the business, which shows that there is at least a promise that we're going to start earning a fair return on our products.

Another result is the remarkable growth in the use of stochastic cash-flow testing in pricing. As more actuaries use and understand the available technology, there is a growing awareness of the inadequacies of what was used before. Since what was used before often painted an overly optimistic picture, it can logically be blamed, in part, for some of the problems our industry has faced.

The next point I would raise is the use of target surplus. A new awakening to the need for capital so that the industry can fulfill its promises has resulted in an increase in the use of target surplus in pricing. For all the reasons stated before, this trend is bound to continue. And though we may not always agree with those outside who scrutinize the life insurance industry, their continued diligence, which is the new, universal paradigm, joining death and taxes, will ensure the life insurance industry's continued emphasis on sound capital growth objectives.

We have recently updated a 1988 survey concerning the use of target surplus and stochastic scenario testing in the pricing process. The changes are fairly dramatic. The percentage of companies surveyed using target surplus in pricing has increased from 55% in 1988 to 74% today. The use of stochastic scenario testing or asset/liability analysis has increased from 10% in 1988 to 43% in 1992. It's nice to see nearly three-fourths of companies reflecting capital management in pricing. Although there has been a large increase in asset/liability analysis used in pricing, we still see over one-half of the companies ignoring assets and asset/liability interaction in their pricing. This is disconcerting, and I hope the trend exhibited from 1988-92 continues in the coming years.

We also updated our survey on ROI pricing objectives. One thing that hasn't changed from 1988 to 1992 is that 50% of the companies surveyed use 15% as their ROI objective. We do, however, see a downward shift overall. Whereas in 1988 companies not at 15% tended to be above it, now in 1992, companies not at 15% tend to be below it. This doesn't necessarily mean we're softening ourselves; it's just reflecting the downward change in interest rates.

I made reference earlier to the use of value-based accounting techniques. Until recently, most companies have been reluctant to introduce one more accounting system. Nevertheless, some companies have begun to awaken to the inadequacies of GAAP accounting. These inadequacies have encouraged some to make imprudent decisions in the past and have often forestalled corrective action. I have a feeling that many of you are aware of situations where company managements have made the wrong decisions for the wrong reasons because they were trying to achieve a certain GAAP result. Value-based accounting is a tool that will help managements not make those wrong decisions. We find there is a growing trend of companies that are at least beginning to utilize these tools.

In our brave new world, there is a growing awareness of the gap between the information needed to make prudent business decisions and the information provided by a GAAP reporting system. Value-based accounting fits the needs of the world of today. Increased scrutiny by regulators and rating agencies has encouraged an increased focus on sound management. This will inevitably lead to the increased use of value-based accounting methodologies.

During the "Jeopardy" game we played earlier, many company names came to mind. To be fair, many of the companies that failed were staffed with a cadre of bright, talented, well-meaning people. Despite their efforts and their successes, a few people in the wrong places did them in. Although problems are bound to recur, one would hope that lessons learned from the past, increased use of better tools, a resulting upgrading in the abilities and knowledge of those who manage, and greater public awareness and sophistication will result in reduced instances of failures.

Taken together, these developments should lead to permanent improvements in the solvency of life insurance companies and to our industry's ability to deliver on its promises; that is, if today's charlatans don't stand in the way. Today's charlatans may be found in strange places, wearing strange costumes (for example, disguised as U.S. senators or as consumerists), but their purpose remains the same: self-aggrandizement and increased personal wealth.

I have a list of major trends to watch, which I think we're all aware of. The first one is, as I said earlier, the focus on core businesses by virtually all companies. I believe that there's hardly a company in the country that has not been looking at core business, asking what its core businesses are, and either has divested or is in the process of divesting one or more businesses it believes are not crucial to its success. Another trend will be the greater use of conventional forms of reinsurance for better risk management and for improved capital management. We find the largest companies in the country now looking to reinsurance as an effective, efficient source of capital. I won't try to sell you on all the good things that reinsurance can do for companies.

A movement toward universal utilization of stochastic modeling technology for pricing and financial management is another trend to watch. Those of you who are involved in that process know very well some of the many things that you learn about your business through these techniques.

As I mentioned earlier, there has been a slow but steady increase in the use of value-based accounting methodologies. Some companies are using it just to analyze their marketing and distribution costs; some companies are beginning to look at it on a companywide basis. It's a trend that's coming because of the inadequacies of the other accounting bases we use. There is a movement toward consolidation in the industry, and I believe that trend will continue. I think the last trend will be a significantly healthier, better-managed life insurance industry. Now I acknowledge that's coming from one of our industry's greatest Pollyannas, but I do believe it.

MR. BRUCE E. NICKERSON: In listening to the things that were said here, there were a few things that I didn't hear, and I was wondering whether it was oversight or whether it was deliberate. I remember back some years ago, there was much discussion of functional cost studies and trying to get a hold of what actual costs were and relating them to pricing assumptions. I have not heard anybody say a word about that kind of cost analysis, not just at this session, but throughout this meeting, and I'm wondering why. Maybe I am just missing the point somewhere.

My second question is that it seems to me that at least a factor in the overall industry solvency problem has been a very material change in persistency and, therefore, the ability to recover initial expenses without a corresponding change in the level of expenses needing to be recovered. In terms of looking to the future, what factors might you see that would perhaps make that relationship a little bit closer to what I think many of us remember it as being in the 1950s and 1960s?

MR. DAVIS: I'll try to tackle the first question, at least as much as I can remember. Companies still do expense studies, as far as I know, and I have seen a few of them. I can think of two reasons why expenses, or cost analysis, have not been featured in our program so far. First, expenses have not been a primary factor in the financial impairment of the "companies on the edge" under discussion. Granted, failing to achieve pricing targets has led to a deterioration of actual margins and inadequate capital in the industry in general. There is no doubt that expenses have contributed a great deal to that failure. I'm not aware, however, of an expense problem that has taken a company to or over the edge.

The second reason why expense levels have been given a back seat has to deal with magnitudes. Forgive me if I sound like Carl Sagan, but our industry manages billions and billions of dollars of assets. The life insurance business is becoming more asset-intensive every day. For many companies, expense concerns pale in comparison to maximizing total asset return or reducing C-3 risk exposure. That doesn't mean expenses aren't important anymore; it just means that for many companies, it's now a different ball game. I've worked with a few large SPDA writers on assignments involving stochastic cash-flow testing. It turns out that a 10% change in expense is minor compared to a 10-basis-point change in yield or default improvement. My response, then, is that although expense amounts represent real money, management effort pertaining to expense control or analysis does not seem to have the same

leverage potential that an increase in realized investment spread could have. The financially impaired companies are typically asset-intensive companies. Expense problems may continue to plague them, but I don't think expense problems brought them to the edge.

MR. YOUNG: What Mark said may explain why, here, we haven't discussed expenses much, but let me tell you what companies are doing in this area. Virtually every company that we come into contact with is looking for some kind of an acquisition. Generally, more times than not, what they're trying to do is bring additional units in house to better manage their unit costs. Also, the other side of that coin is that many companies are looking at inefficient operations and looking to divest them, and so there's huge activity. I would bet that most people here are involved with an insurance company that has been recently involved on one end of that type of transaction. Companies are looking at staffing cuts. I mentioned *The Wall Street Journal* article; several other articles talk about companies looking at the efficiency of operations from that regard. We are seeing more companies looking at their costs.

I mentioned one particular company that's using value-based accounting methodologies. It's a major company, and it is studying its distribution systems and distributors, and it is looking at the actual expenses compared to what it has put in its products. It is effectively repricing products. It is getting rid of inefficient distributors, and it is deemphasizing certain distribution systems. It is also raising prices on products. We see that kind of activity, and I don't think that activity was very common a few years ago. But because of some of the bad things that have happened, that some of us have had to go through, I think some lessons have been learned and I do think things are improving. I just hope that our collective memories last long enough for this to be meaningful and for the trend to continue for some period of time.

MR. DAVIS: Could you repeat the second question, please?

MR. NICKERSON: Basically, the second question was that the costs of getting new business on the books don't seem to have changed much. But because of changes in persistency, the recoverability of initial expenses seems to me to be drastically different. That equation, as I see it, has changed. Are there factors that are occurring that are likely to, in some manner, readjust more favorably that relationship between distribution costs and the recovery of those costs?

MR. YOUNG: Well, I know many of our larger clients are focusing very heavily on agent retention and have looked to see what impact an increase in agent retention has. It's dramatic, and they're working along those lines. Now, I don't know if anybody has the right answer yet, but certainly that's one thing they're doing. Walt, what are your clients looking at?

MR. WALTER S. RUGLAND: Everything they possibly can think of. I would comment that the real problem is whether you wish to maintain a high-cost distribution structure and make it acceptable to see low-margin products. The emphasis needs to be, and I see it moving that way, on managing the mix of the business being sold by the distribution system and relating that back to the type of distribution system in the structure you want to have to support it. I believe that we're probably three years

into that, and it's probably going to be five years more until it sorts itself out. Some companies will say they are in the life insurance business, and they intend to maintain the structure that it takes to sell life insurance. And other companies are going to have to say they are in the annuity business or the health business, or whatever, and that requires a different distribution structure.

MR. YOUNG: It's an amazing eye-opening exercise. I'm sure you've seen that as well, Walt. Companies look at distribution systems they felt were very profitable and distributors that were their major producers, and suddenly, they realize that they're losing a lot of money and they have to do something about that. They have to take the first step.

MR. DAVIS: Concerning the other aspect of your question, though, you seem to imply that lapse rates have deteriorated recently, and it's getting tougher and tougher to amortize or recover the initial acquisition cost. I'm not sure that I agree with that. I certainly haven't seen every company out there, by any means, but the few that I work with very closely have not experienced any increases in lapse rates in the past five years. In fact, I believe industrywide lapses have decreased since 1983 or 1984.

MR. NICKERSON: Oh, no. I'm using a totally different time frame. I'm comparing it to 20 years ago.

MR. YOUNG: Oh, okay. Because it has tempered more recently.

MR. NICKERSON: I believe persistency has deteriorated dramatically from what it was in the 1960s.

MR. DAVIS: I might also add that, in some respects, underwriting costs have decreased recently because of the availability of some new underwriting tools. For example, the saliva test has been developed recently and is quite cheap to administer. I know when I bought a large life policy a few years ago, I had to give blood and urine. They came to my house as opposed to me going to a doctor or clinic. I don't know what lab they used. But to me it seemed very cost-effective. I think relatively speaking, there are certain costs of acquisition that have at least stayed the same, if not decreased. Marketing and agency costs may have risen over that time frame.

MR. RUGLAND: I have an additional comment in a different vein. I just want to express my encouragement with respect to the response of the industry. I agree with Mel that things are looking better and that decisions seem to be a little bit more focused on what it will take to be around in the long term. I do think that we can fool ourselves in terms of the accounting systems we're using to decide whether or not we're better. I'm not sure that the economic health of the industry has changed as much as the statutory surplus accounts have, but I'm encouraged with the way we're going.

Another thought I have is that, in my mind, cash-flow testing is not just C-3 testing; it's C-1, C-2, and C-3 testing. As we go forward, we're going to refine those tools more and more, so that when we do cash-flow testing, we will be thinking about everything.

You asked a question, Mark, about where the actuaries were. I've written about that. The actuaries were told to stay home. That's what I talked about in my address. I think about five years ago, we recognized that it wasn't appropriate for us to stay home, and we started working and putting together a foundation that would allow us to deal with the issues we are trained to analyze. We have begun to realize we don't have to always play in other people's sandboxes, that we could define, as we've talked about here, some accounting systems that would help measure the economic health of the life insurance business on a long-term delivery-of-promises basis. I think we're ready to deal with the long-term view. And, in fact, that's what no one has wanted to talk about until now, and the time is right to do just that. I'm very confident that, with value-based accounting and some other things, we will be able to provide some support to management to really be around for a long time and to deliver on our promises.

MR. YOUNG: We shouldn't totally cop out of that one, though, because there were some situations where actuaries could have been more vocal. And, granted, as in Fred's case, you had a situation where the basic problem happened outside the life insurance company, but somebody could have made noise much sooner.

Some people in other companies that have had difficulties might want to address that. I know the actuaries were making noises, but, obviously, they weren't loud enough.

MR. RUGLAND: I believe we have bases or foundations in place now, so that if individuals are ready to do that, they will have a lot of support behind them, and it's going to be nothing but better in the future.

MR. KIN K. GEE: I'm just amazed what nobody has mentioned in response to Bruce's question. The whole product design has changed dramatically from what it was 10 or 20 years ago. We see products now that break even in 2 years, versus 7-10, possibly up to 15 years in the past. That's a major change for the industry in general, in terms of financial economic interest of the industry.

MR. DAVIS: You must be referring to newer asset-intensive products. Since I've been around, I don't think the break-even year or the recoverable period has changed much for life insurance. But, you know, I'm relatively young compared to my fellow panelists. In September 1989, I wrote "The Standard Nonforfeiture Law: In need of change," which was published in the *Product Development News*. The paper discussed this very issue, and also how the standard nonforfeiture law tends to prevent us from breaking even sooner than we do. It's interesting that there's no nonforfeiture law in Canada or the U.K. I think their insurance industries, generally speaking, have been healthier than ours. Canada just had its very first life company insolvency. Now I know at the time that the nonforfeiture law was enacted many abuses were going on, and the nonforfeiture law was very popular. My own personal opinion is that it hurts the industry. I truly think that the market should decide the level of cash values or policyholder values. I think we should be competing in the long term, not in the short term. Most policyholders, when looking to buy a universal-life policy, will pull out the illustrations and wonder which company will give the highest values five years from now, or ten years from now. If you're concerned with having the highest values five or ten years out, I'd say you're buying the wrong

policy. You should be buying term insurance and investing the difference. Values at age 65, or how does it look 30 years down the road – that's what you should be looking at if you're buying a permanent product.

If you want to improve things, consider what products we could have if we had no nonforfeiture law. The U.K., for example, has many types of unit-linked insurance. For us, the equivalent product is variable universal life. Some of the unit-linked products have 100% front-end loads for three, sometimes four years. Nearly all of the profit the insurer makes is made in that time, and from there on out they're managed on a near-break-even basis. Because the costs are recovered so much quicker, you are ultimately able to provide policyholders with better long-term value.