small talk

Newsletter of the Smaller Insurance Company Section

ISSUE 12 DECEMBER 1998

From the Editor

by James R. Thompson

Marketing Problems

Companies these days seem to be looking for approaches to increase sales. One approach they are trying is database marketing. Another is worksite marketing. Larger companies often create strategic business units to work on this or otherwise have large resources. We will explore how best to handle these approaches to new sales within the budgetary constraints of the smaller company.

A recent issue of the *National Underwriter* (August 31) carried some articles on these themes. Some of the authors were contacted and have contributed other material they have written to this issue of *small talk*.

If you have policyholders on a database, you have potential leads. How and when to contact them can make for a successful strategy for increasing your application count. Large companies have extensive staffs they can devote to this. How can the smaller company make efficient use of their database? Wallace Dale has contributed an article on database marketing entitled, "Collaborative Database Marketing."

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Small Company Update on XXX

by James N. Van Elsen

It seems that I have been saying throughout my whole career that "XXX is coming." Every time, I truly have believed that nothing could stop it. Well, one more time, XXX is coming!

For those who have not been following this regulation, XXX is a name that has been used to identify a new individual life insurance valuation regulation. Although it was primarily designed to affect reserves for individual term life insurance, it may ultimately affect all individual life insurance products. There are currently a few exclusions in the draft regulation, but even these are under review.

"The new version of XXX will become effective for most companies on January 1, 2000."

The driving force behind XXX this time is the states of Wisconsin and New York. A version of XXX has been in effect in New York since 1994. This has not had a major impact on the industry due to the relatively small number of companies that are licensed in New York. Wisconsin, however, recently adopted XXX with an effective date of January 1, 1999. This has the potential of affecting significantly more companies.

An Ad Hoc Industry Committee has been working to develop an alternative version of XXX. While much work remains, it now appears that the committee may succeed in having the NAIC adopt this alternative regulation. Based on the success of this group, Wisconsin has indicated that they will move the effective date of their regulation back to July 1, 1999. If the Ad Hoc Industry Committee is successful, it is anticipated that Wisconsin will adopt it, moving the effective date back to January 1, 2000.

Current Status

The following is a summary of the status of XXX as of October 13, 1998.

- Exposed for discussion by the NAIC's Life & Health Actuarial (Technical) Task Force and the "A" Committee on September 12, 1998.

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In the field of worksite marketing, Rick Storms has written an article on how to work with the employer. It is called "Financial Education: Employer Trends, Liability and Considerations." This is important in order to achieve success. Patrick Lusk has written one entitled "Critical Illness: The Next Great Worksite Sale." This is a special market. A generic article was written by Norman Hill, a member of the Smaller Insurance Company Section Council. This is based on his own company's experience over the years in this market. Al Barthelman has written a general article entitled "How to Succeed in the Worksite Market."

Sales are generally in a slump. Smaller companies have both advantages and disadvantages. They have smaller resources but they can react quickly. Many large companies try to remain competitive by using strategic business units (smaller companies within themselves) to react quickly and still have access to major capital and resources. Smaller companies have to carefully understand how to accomplish something without so much backing. Consider that when reading the above articles. How can one use the ideas of a small budget? Some of the authors are consultants and might be able to help out.

A small company has been compared to a submarine. It can turn on a dime. Everyone's contribution is visible. There is no place to hide. On a battleship, turning is a major project and many ensigns are anonymous for a whole mission. In your company, learn how to make your effort count!

Regulation

In many offices, I have seen the humorous expression: *Nobody's life or property are safe while the legislature is in session.*

With the fast pace in regulation, many managers in small companies are distinctly getting that impression, although "legislature" can be broadly extended to various regulatory bodies. There are so many, it is difficult to know where to begin. Perhaps the best place is an article from the *Newsletter of the National Alliance of Life Companies* (NALC) entitled, "Industry Liaison Committee Discusses Small Company Survival." Whenever we see regulations, we should ask ourselves whether they are necessary or material or cost-effective. Please keep this in mind when reading about any of the regulatory issues discussed.

XXX

Perhaps the most important issue we face as of the date of this publication is Alternative XXX. Because XXX is due to take effect in Wisconsin on January 1, 1999, an industry group representing widely diverse interests has constructed an Alternative XXX. Participants have included Northwestern Mutual and other large mutuals that have generally supported XXX, many stock companies that write level premium reentry term and oppose XXX, as well as many others. I have attended several of the key meetings.

One reason this is important is that it is on the fast track. To stave off the implementation of XXX in Wisconsin, action is expected at the December 6 meeting of the NAIC. To iron out details, there have been several conference calls. We are pleased to have two articles on this. One is an excerpt from the September issue of the NALC's newsletter. The other, "Small Company Update on XXX," was written specially for *small talk* by Jim Van Elsen. He and the NALC have been very active in presenting the industry alternative XXX to the NAIC.

To paraphrase Abraham Lincoln: a compromise is something which is agreed to but which nobody really wants as is. Everyone gives in a little to reach a working relationship. Alternative XXX is such a regulation. It definitely reminds me of the old adage: No one wants to see good sausage or legislation being made. This compromise is already being criticized before all the details have been worked out.

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The Feeling Was Not Mutual

by Edward J. Slaby

On Friday June 19, 1998, the New York State Legislature adjourned for the year. During that week there was a frenzied effort to put together legislation authorizing mutual life insurance companies in New York to reorganize as stock companies through the formation of upstream Mutual Holding Companies (MHCs).

New York is the home state of ten mutual life companies, ranging from giants such as Met Life and New York Life, to smaller companies such as Unity Mutual. The estimated market value of these ten companies is more than $40 billion, so it is not surprising that the New York State legislature, and in particular the Assembly Insurance Committee, would closely scrutinize the proposed legislation and also that it would become a political football.

MHCs allow the sale of a minority stake in the company to outside stakeholders.

The large New York mutuals wanted a bill authorizing MHCs primarily so they could make acquisitions in the rapidly consolidating financial services sector. For the small companies, the MHC structure would be a way station on the road to possible full demutualization, when circumstances and preparedness are more appropriate. The alternative for all companies that wished to shed their mutual structure was a conversion to total stock ownership.

A defining moment in the trajectory of the New York MHC legislation came on October 8, 1997, at a public hearing held by the Insurance Committee of the New York State Assembly. In addition to the Insurance Superintendent, there were more than 30 witnesses who testified, including mutual company CEOs, state regulators, legal specialists, consumerists, journalists, and academics.

The proposed bill seemed to have excellent prospects for consideration and passage. It was a Governor's Program Bill and had the support of the Insurance Superintendent. The mutual companies in New York, large and small, were behind it. However, significant opposition emerged at this hearing from various parties who spoke in opposition to the bill, which they considered to be, variously, "... ill-conceived" (David Schiff), "... an executive self-enrichment scheme" (Ralph Nader), and "... fundamentally flawed" (Joseph Belth). James Adkins, a constant MHC gadfly, proved to have detailed and well researched facts and opinions in opposition to the bill.

The result of this and subsequent public hearings was a report published in March 1998 by the staff of the Assembly Standing Committee on Insurance. The title of the report, "The Feeling's Not Mutual," telegraphed its contents. This report methodically dissected the testimony from the hearings and concluded that the proposed bill was unfair to the participating policyholders, failed to protect their interests, and generally would produce a result which was not in their best interests. The report concluded that policyholders in a MHC transaction would give away up to 50% of their interest in the company and receive no compensation in return.

The New York mutuals made a last frantic effort in the hurly-burly of the last week of the legislative session to find a way to get the legislation "unstuck" from the Assembly Insurance Committee. Three high-powered lobbyists were deployed in support, as well as the industry's State Trade Association. A large mutual company's CEO truncated his vacation to return to the fray in Albany. The small companies were also represented by a skilled negotiator from their ranks.

Day to day, reports of prospects for the bill varied widely from unwarranted optimism to extreme realism. Finally, the word came that there was no deal, and the bill was dead for the session.

In retrospect, the Assembly Insurance Committee was not going to forward a bill whereby the mutual policyholders are not fairly compensated for what they are perceived to give up. The industry's negotiating intelligence seems to have been less than adequate, as evidenced by the fact that no proposal was ever forwarded by the industry side that even came close to what the Assembly leaders had all along said they wanted. There may have been too much reliance on political maneuvering, and not enough attention to substance, to get passage of the bill. The issue may best be summarized this way. If the company were to demutualize, the policyholders would receive 100% of its value. If a company were to reorganize as a MHC, the policyholders would receive 0%. A compromise would seem to be indicated.

So where does this leave the New York mutuals? Some of the large companies have already begun the costly and time-consuming effort of demutualizing. Others are studying it. The small mutuals most likely will survive but, in my opinion, the failure to pass the MHC in New York means that they will not be given a reasonable opportunity to thrive.

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Bob Barney is again raising the issue of differences between the length of time that premiums are illustrated level and guaranteed. With XXX he feared that the five-year exemption from deficiency reserves would cause companies to underprice and then raise the premiums after five years. Even though this exemption has been eliminated in the industry proposal, he wants premiums to be illustrated and guaranteed for the same length of time.

One way to in-effect require that companies guarantee premiums for as long as they are willing to illustrate them as level is to base the segmentation on the illustrated (current) premiums rather than the guaranteed premiums. Doing so will obviously raise the premiums but also make sure that the consumer will not have to fear premium increases before the end of the level period.

Alternative XXX, however, is basing the segmentation of the guaranteed premiums on the rationale that companies can experiment with the various combinations of amount of premium, length of guarantee and length of illustrated level premium. The public will have to read the illustrations and sales literature and make the choice they want.

Be prepared to read much about this in the next few months and to be called on to comment. Ultimately, this deals with regulation and free choice and with the trust imposed on companies to price in a bona fide manner.

To understand why the Alternative XXX has only 20-year select mortality factors rather than the originally proposed 25-year select, read the article by Jim Reiskytl.

There is another aspect of this regulation which affects smaller companies. This deals with the ability to use X% of the mortality standard (X is less than 100) for deficiency reserves. There are two criteria. One is that the actuary must opine and issue a report to justify the use of X%. The other is that the actuary must do an actuarial memorandum (Section 8 opinion). As near as I can tell, all the big writers of level premium reentry term, as well as the mutual companies that seem to support XXX, do annual memoranda.

However, there are small companies which use reinsurers in their term ventures. Let us say that the reinsurer has enough exposure that it can justify some X% of the mortality assumption. It can price the product a certain way and hold reserves on that basis. The ceding company should be able to hold the same reserve basis. But can it? If it does not have to do an annual memorandum, now it must do so. Perhaps not using the X% for deficiency reserves will cause the price to be raised. But doing the memorandum is an extra cost. This seems to me to be an example of a regulation creating an unnecessary cost for smaller companies. I believe this could be changed by simply deleting the requirement for the memorandum. Also, there should be an actuarial standard for the report. We should make sure that companies should be allowed to use a reinsurer's assumption. I raised this at an industry meeting on September 3, but it would be helpful if actuaries from the smaller companies, as well as the reinsurers who deal with them, raised this also.

Late Development

While this issue was being assembled, there was a conference call of the Life and Health Actuarial Task Force (LHATF) with industry people. Various issues were ironed out and a final conference call was set for November 18. Whatever comes out of that will go to the NAIC in December.

Of particular note is a proposal by Jack Gies from the Connecticut Department. He is proposing that the mandatory asset-adequacy analysis be replaced with some sort of demonstration of asset-adequacy for the block involved but not involving the seven scenarios of cash-flow testing. He is still formulating his proposal. This has a lot of promise for smaller companies to avoid an onerous requirement for total company cash-flow testing where none may have been done before. We should work with him to develop this.

One thought is that, if a small company must do illustration actuary work, that could be used. He is talking about sensitivity testing. Perhaps illustration actuary work with sensitivity on key assumptions could be used. This would be a lot better than the currently proposed Alternative XXX. During the call, we even decided that the current Alternative XXX would require a total-company asset-adequacy analysis if a company wrote XXX term and reinsured 100% of it. Even if this newsletter does not get to you by November 18, do what you can to lobby for eliminating the total company asset-adequacy analysis. Contact Jack Gies (860-297-3943) or Mark Peavy of the NAIC (816-374-7257).

Mutual Holding Companies

The creation of mutual holding companies is an important part of the insurance scene. This affects their competitiveness and ability to raise capital. The failure of one law in New York is instructive. Ed Slaby, an actuary with a New York mutual, has given us his views in this issue of *small talk.*

AOMR

The Actuarial Opinion and Memorandum Regulation is constantly being discussed among regulators. They want to be able to handle developments in both the assets and liabilities. Companies want a manageable regulatory environment. I have written an article on the latest developments on AOMR.

Summary

Smaller companies must be able to react quickly in the marketplace. If you have any ideas on worksite marketing or database marketing, we would like to hear from you. If these articles have helped you in any way, feel free to write about the results.

On the regulatory front, there are so many developments that we have only covered what we view as the most important. Your opinions matter. Regulators will listen to input. Those who provide none should not be surprised to find themselves left out.

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Small Company Update on XXX
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Copy can be downloaded from the NAIC's web page at http://www.naic.org/committe/modelaws/0698docs/3xre1.doc

- NAIC's Life & Health Actuarial (Technical) Task Force may adopt it at the December meeting in Orlando.
- NAIC's "A" Committee may adopt it at the December meeting in Orlando.
- NAIC's Executive Committee may adopt it prior to the March meeting in Washington, D.C.
- NAIC may adopt it as soon as the March meeting in Washington, D.C.
- Several states are expected to adopt it during 1999, including Illinois and Wisconsin. Other states are expected to join this list.
- The new version of XXX will become effective for most companies on January 1, 2000.

If the Ad Hoc Industry Committee is unsuccessful, Wisconsin and several other states are expected to adopt the previous version of XXX very quickly. In any event, most companies are expected to be affected by XXX by January 1, 2000.

Small Company Aspects

There are several aspects of the proposed XXX that should be reviewed by smaller companies. These include:

- The "X" factor.

The proposed regulation has an "X" factor that is used for deficiency reserves. This factor, which may be a vector, is multiplied by the 1980 CSO mortality table to arrive at valuation mortality for deficiency reserves. It is expected that the Actuarial Standards Board may develop an Actuarial Standard of Practice to guide appointed actuaries in establishing "X."

It will be more difficult for smaller companies to justify aggressive values of "X." They will be much less able to use their own experience to document the anticipated level of mortality. They will be forced to rely on industry experience. This may also force them to work with reinsurers to justify "X" based on reinsurance premiums or pooled business. It is unclear at this point what options will be available to smaller companies for justifying experience.

If "X" is less than 100%, a company must prepare a Section 8 Actuarial Opinion (Asset Adequacy Analysis). In addition, companies will be required to prepare an actuarial opinion and report justifying the use of any "X" factor less than 100%.

Finally, the impact of future changes in "X" on smaller companies can be devastating. For example, let's say that the appointed actuary establishes "X" at 40% for a new series of term products. As experience evolves, it may become apparent to the appointed actuary that 80% is necessary. The company will be forced to recalculate deficiency reserves at that time based on the 80% "X" factor. It's possible that this product previously had no deficiency reserves. The company may now discover that the product has very significant deficiency reserves, perhaps enough to impair the company.

It is important, therefore, that the appointed actuary be very careful in establishing the "X" factor. A too aggressive assumption may later be disastrous for the company. It may be necessary for the company to seek some reinsurance protection from adverse results of increases in "X."

- Valuation complexity.

For products that are affected by XXX, the reserve calculations can be complicated. This may necessitate modifications to valuation systems, or even new valuation systems. This will also complicate the pricing models that a company uses to develop new products. Smaller companies do not generally have as many resources that can be devoted to these valuation projects. To remain competitive in the term market, however, companies will be forced to implement these changes.

- YRT reinsurance exemption.

There is an exemption in the regulation for "true" YRT reinsurance. Contracts which meet certain definitions are exempt from the requirements of XXX. The ceding company reserve credit, however, will be limited to the amount of the reserves held by the assuming company for this business.

- Universal life products.

Universal life insurance has traditionally been the product choice of many smaller companies. XXX specifically addresses reserving issues for universal life policies with secondary guarantees. Essentially, the secondary guarantees (some companies refer to these as no-lapse provisions) will be treated as a term product within the universal life product. The company will be required to hold the greater of the normal universal life reserve or the reserve developed by XXX.

If XXX becomes effective in the year 2000, it can be expected to significantly change the individual life insurance marketplace. As noted above, some of the provisions of XXX need to be reviewed by smaller companies. It will be extremely important for smaller companies to monitor the progress of this regulation, and to develop plans for adjusting for the impact of this regulation. Failure to respond appropriately to this regulation could be very costly to smaller companies.

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LHATF Exposes Revised Regulation XXX

The following are excerpts taken from the newsletter of the National Alliance of Life Companies (NALC) and are reprinted with permission.

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Is it possible that the NALC version of the amended Regulation XXX will be adopted in 1998 by the NAIC? Mindful of the looming crisis in the term insurance market, the Life and Health Actuarial Task Force (LHATF) exposed the latest proposal from the Ad Hoc Industry Committee on "XXX" (AHIC) organized by the NALC in August 1997. The regulators also committed to a schedule which would have LHATF and the "A" Committee adopting "XXX" by October 5, 1998. At that time, it would go to the Executive Committee for consideration at its interim meeting. If all goes well, the NAIC Plenary could adopt XXX at the Orlando meeting in December.

Timeline

The following timeline is anticipated if everything goes well for the adoption of "XXX."

1. Adoption by LHATF by conference call — October 5.
2. Joint adoption by LHATF and (A) Committee — October 5.
3. To Executive Committee — October 5.
4. Adoption by Executive Committee before December NAIC meeting.
5. Adoption by Plenary — December 6.
6. Adoption by states — 1999.
7. Effective date — January 1, 2000.

Proposal Overview — Applicability

This regulation potentially affects **all** life insurance policies, **with or without** nonforfeiture values. The following types of policies, however, are **not** subject to the regulation:

1. *Reentry policies* — Policies which are reentries from policies issued prior to the effective date are not subject to the regulation. There are conditions that the reentry policies must meet in order to be exempt.
2. *Universal life policies with short secondary guarantees* — Universal life policies which meet the following conditions are exempt:
   a. Secondary period (if any) is five years or less.
   b. Premium for secondary guarantee is at least net level premium.
   c. Initial surrender charge is at least the premium for the secondary guarantee.
3. Variable life insurance
4. Variable universal life insurance
5. Group life insurance — Unless provides for a stated or implied schedule of maximum premiums for more than a year.

Basic Reserves

Traditional "humpback" reserves are held for each level-premium segment. A "humpback" reserve is a traditional term reserve for the duration of the segment. At the end of the segment, the terminal reserves will normally return to zero.

The end of a level-premium segment is determined when the percentage increase in guaranteed premiums is greater than the percentage increase in valuation mortality. For a normal 5-year renewable term policy, there would be a series of 5-year, level-premium segments.

Unitary Reserve Test

Unitary reserves, if greater, must be held instead of the traditional "humpback" reserve. For unitary reserves, net premiums are calculated as a constant percentage of guaranteed premiums for the life of the policy. For the 5-year renewable term policy, the net premiums would be a constant percentage of the lifetime schedule of guaranteed premiums.

Valuation Basis

The valuation interest rate for "XXX" reserves is the same as is used for other CRVM reserves. A full CRVM expense allowance may be taken in the "humpback" reserves for the first segment and for the unitary reserves. All currently acceptable versions of the 1980 CSO Table may be used for the mortality basis. In addition, the regulation provides for the use of new mortality 20-year selection factors. These factors may only be used during the first segment.

Deficiency Reserves

Traditional deficiency reserves must be calculated for all policies subject to this regulation. A deficiency reserve is defined as the excess of minimum reserves, if any, over basic reserves.

Minimum reserves are calculated using the lesser of the guarantee gross premium or the calculated net premium. The method of calculating the net premium is the same as that for basic reserves, except for the valuation mortality table.

Deficiency Mortality Table

A company may use a mortality table eligible to be used for basic reserves with no restriction. Alternatively, the company may choose to select a more aggressive table. This table uses the 20-year selection factors provided for basic reserves. The valuation actuary may multiply these selection factors by any ratio (X), subject to the following:

1. X may vary by policy year, policy form, underwriting classification, issue age, or any other policy factor expected to affect mortality experience.
2. X must be at least 20%.
3. X cannot decrease in any policy year.
4. The present value of future death benefits using the resulting valuation mortality, just be at least as great as the present value of future death benefits using anticipated mortality experience.
5. The resulting valuation mortality must be greater than the anticipated mortality experience during each of the first five years after the valuation date.
6. X must be increased anytime it is necessary to meet all these tests.
7. X may be decreased anytime as long as it continues to meet all these tests.

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Financial Education: Employer Trends, Liability and Considerations

by Rick Storms

Today's employers recognize the growing need to help employees take charge of their financial future. To accomplish this, many employers are turning to financial education programs to add value for their employees without adding benefit costs. In fact, the 1998 International Society of Certified Employee Benefit Specialists (ISCEBS) survey indicates benefit specialists' top priority is providing investment education to employees.

A number of industry trends are driving employer interest in — and employee need for — financial education:

- **Limited retirement planning:** Various studies show many employees are saving only a fraction of what they need to maintain their current standard of living at retirement. This may be particularly true for baby boomers and younger employees for whom Social Security retirement benefits will likely play a smaller role. In addition, many employees do not have access to a financial services professional, and look to their employer for basic financial information.

- **Lack of information:** Most employers offer limited financial information, generally focused only on the 401(k) or benefit plan. While benefits education can be effective, it may be more helpful to present this information within the context of a complete financial plan. Furthermore, education helps employees better understand their existing benefits.

- **Demand for convenience:** Employees like the convenience of buying insurance and financial services at the workplace. According to a LIMRA study, three out of four employees are open to buying these services at work.

Financial Education: A Win-Win Strategy

Here are some of the advantages of implementing a financial education program:

Benefits for Employers
- Promotes shared responsibility
- Reinforces value of retirement plan
- Increases understanding of benefit offerings
- Provides general retirement planning information, encouraged by the Department of Labor
- Aids recruitment and retention efforts

Benefits for Employees
- Provides opportunity to develop an actionable plan
- Provides a useful and tangible employee benefit
- Promotes active participation in financial decisions
- Helps increase money management skills
- Helps reduce financial worries and builds financial confidence

How Financial Education Helps Employers Comply With 404(c)

404(c), a subsection of ERISA, permits employers to provide certain information to employees without becoming fiduciaries. Employers must give plan participants at least three different investment choices, participants must have independent control over their accounts, and they must be given sufficient information to make informed investment decisions.

Recently, the Department of Labor issued an Interpretive Bulletin to add clarity to what constitutes "sufficient information." This bulletin identifies four categories that, appropriately, will *not* constitute the rendering of investment advice: 1) Information on the specific retirement plan, 2) General financial and investment information, 3) Asset allocation models, and 4) Interactive materials.

The Department of Labor encourages employers, particularly those with defined contribution plans, to provide financial education to help participants and beneficiaries maximize their benefits under the plan. Implementing a financial education program with the four categories of information listed above, can assure employers will not lose the special exemption from fiduciary status set forth in ERISA section 404(c).

Ten Considerations for Evaluating Financial Education Programs

Since employee financial education is still fairly new, many employers need assistance in how to evaluate these programs. Listed below are some things to consider before selecting a financial education program:

- Is the financial education curriculum broad-based or topical in focus?
- Does the curriculum address generic financial concepts or vendor-specific products?
- What is the instructor's background, training and experience?
- Is the program varied in its delivery, with applicability for adult learners?
- Is it conveniently held at the workplace?
- Are spouses/guests encouraged to attend with employees?
- Does the program provide an opportunity for participants to meet with the financial educator/advisor to translate knowledge into action?

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Revised Regulation XXX
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8. If a ratio less than 100% is used for any policies, the company must comply with the following:
   a. An actuarial opinion based on asset adequacy analysis (Section 8) must be prepared for the company.
   b. The appointed actuary must annually opine as to whether X meets the requirements of this regulation.

Universal Life

For the purposes of this regulation, universal life policies with secondary guarantees must hold the greater of reserves calculated by this regulation and the reserves required by CRVM for universal life policies. Secondary guarantees are provisions in universal life policies that allow a policy to remain in force, even though the current surrender value (or in some cases, account value) is negative. These provisions usually allow the policyholder to pay a minimum premium to guarantee the policy does not lapse. To calculate the "XXX" reserves, the secondary guarantee periods are viewed as a term policy within the universal life policy. The same calculation rules are used for these policies as are described above.

Other Provisions

1. Minimum reserves. When all the calculations are completed, the company must still hold at least 1/2c, or the "cost of insurance" to the paid-to date, depending on the valuation method.
2. Unusual patterns of guaranteed surrender values. Additional reserves may be required if the scheduled premiums are not sufficient to fund future guaranteed increases in surrender values.
3. Optional exemption for YRT reinsurance.
4. Optional exemption for attained age YRT policies.
5. Exemption from unitary reserves for certain n-year renewable term policies.
6. Exemption from unitary reserves for certain juvenile policies.

Effective Date

The regulation will be effective for policies issued on or after January 1, 2000.

Changes Overview

The following are changes that were made to the "XXX" regulation (95 Reg) as adopted by the NAIC for this proposal:

1. The 5-year safe harbor was eliminated. Universal life policies which meet certain requirements are exempt.
2. The selection factors were updated. The 95 Reg had 15-year selection factors based on experience for the years 1983–1986, loaded by 50%. The proposal uses 20-year selection factors based on the same experience, improved for 15 years, then loaded by 50%. During the last five years, and at older ages, the rates were graded into the 1980 CSO Table.
3. New deficiency mortality standard. The 95 Reg used the same mortality as for the basic reserves, loaded 20% instead of 50%. The proposal relies significantly more on the professional judgment of the appointed actuary. A company will be permitted to multiply the selection factors by ratios that are as low as 20%. *Please note: There are several requirements which must be met, however, including the filing of a Section 8 opinion and an annual opinion on the resulting valuation mortality.*
4. YRT reinsurance exemption limitation. The ceding company will be limited to a reinsurance reserve credit no greater than the reserves held by the assuming company. This only applies to policies for which the assuming company elects this exemption.
5. Effective date. Changed from an uncertain date in the 95 Reg to January 1, 2000, in the proposal.

Status in the States

Wisconsin

The state of Wisconsin has adopted the 95 Reg with an effective date of January 1, 1999. If specific action is not taken by the Wisconsin Department of Insurance, this will be the effective date in Wisconsin.

Representatives from the Wisconsin Department of Insurance were present at the LHATF meeting in New York. They have expressed a strong willingness to consider the proposal for Wisconsin, if they can be confident of a 1998 adoption by the NAIC. It is hoped that they will accept the (A) Committee's adoption on October 5 as sufficient evidence to move back the effective date for Wisconsin. The following is an outline of possibilities for outcomes in Wisconsin if the regulation becomes effective on January 1, 1999:

Companies *licensed* in Wisconsin, even if they do not sell term in the State, but sell it in other states, will be subject to the regulation for business written in *all* states. As result it is likely that many companies will immediately reduce initial premium guarantees for *all* states to five years. This may lead unaffiliated companies to discontinue writing term insurance

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Revised Regulation XXX
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in *all* states until products can be modified and supported administratively. Larger companies will likely continue to write products with longer guarantees using affiliated companies not licensed in Wisconsin. There would likely be a large, immediate reduction in consumer choice for term insurance in the country.

It is unclear whether Wisconsin will adopt the new proposal with the January 1, 2000, effective date. It is still possible that they could adopt the proposal with a January 1, 1999, effective date. Unfortunately, this will yield similar results as adopting the 95 Reg on January 1, 2000. The only difference is that companies will eventually move the guarantee periods out from five years.

The only possibility for a reasonable transition from the current term market to the one which will develop after the adoption of "XXX" is adopting the Proposed Effective date of January 1, 2000. Companies will have all of 1999 to develop products that are priced to reflect the costs of the new valuation regulation. If several states adopt the regulation with a January 1, 2000, effective date, larger companies will not be able to circumvent the regulation by avoiding states that have adopted the regulation.

Many companies, including several Wisconsin domestics, can be expected to urge Wisconsin to move back the effective date to January 1, 2000.

Financial Education
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- How is the financial educator/advisor compensated?
- How does the program provide ongoing education to all employees?

Employee Financial Education: The Time Is Now

I believe the time for employers to implement financial education programs is now. Consider one final factor. The implications of individuals not prepared for a secure financial future are tremendous. If employers and the benefits industry in general do nothing, the magnitude of this issue will soon dwarf any other societal issue. The government will have to impose solutions on employers. It doesn't take a long history lesson to remember changes in our nation's overall health care system were almost mandated on employers. The same could happen in five or ten years in regard to employees retirement funding, college funding and other financial educational needs. This leaves a window of time for employers to jump in and provide financial education to employees on their terms as opposed to terms mandated from Congress. Properly designed financial education programs can help employees take financial stumbling blocks and turn them into building blocks. As we draw near the year 2000, the proactive employers will lead the way into the new millennium.

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Alternative XXX Model Regulations from a Federal Income Tax Perspective

by James Reiskytl

Anytime anyone proposes new select factors for the existing generally recognized mortality table — the 1980 CSO table — the life insurance industry must be concerned about both its potential tax impact on the definition of life insurance and on reserve deductions.

The definition of life insurance affects every permanent plan of insurance sold by the industry, under section 7702 of the tax code. Any change in reserve deductions, under section 807, is effective after the new table has been adopted by 26 states. Today, reasonable mortality charges used in the definition of life insurance are based on the 1980 CSO table without select factors.

As discussed in the remainder of this article, in our opinion, these concerns have been successfully addressed and dealt with in the newly revised Alternative XXX model regulations.

Background

At its May 1998 Meeting, the ACLI Board of Directors had approved support of the proposed XXX Alternative subject to satisfactory resolution of specified ancillary issues — one of which was federal taxes.

An ad hoc industry group was formed, chaired by Jim Reiskytl and Armand dePalo, to revise the select factors or limit their use, if necessary, so as to satisfactorily address the tax issues. The tax working group would interact with the Actuarial Valuation Working Group to hopefully find an acceptable solution from both valuation and tax perspectives.

The primary products affected are level premium term insurance and universal life policies with secondary premium guarantees. The alternative proposal had to cover both basic reserves and deficiency reserves. The time frame was very tight. The tax group's goal was to determine alternative choices that would be almost universally supported by tax professionals by the end of July 1998.

Tax Ad Hoc Working Group

Three teams were formed. The first, chaired by Frank McCarthy, was to build a model for the industry to test any alternatives recommended or suggested to determine if the mortality table "generally yields the lowest reserves" as required by section 807(d)(5)(E). This team was also to gather industry data (sales and lapse rates by gender, age, product) from LIMRA and an ACLI intercompany survey.

Team 2, chaired by Jim Lodermeier, developed alternatives to the original proposed table of 25-year select factors that would not (working with the Team 1 model) produce generally lower reserves than those using the 1980 CSO aggregate mortality table. Team 2 was not to be inhibited by the likely impact or acceptability of the new select factors. Its goal was to mathematically create as many options as possible. Options considered included shortening the select period, increasing the select factors, changing the slope of the select factors, redoing the grade into the 1980 CSO table and other variations, including combinations of the above.

The third team, chaired by Ed Robbins, considered various ways of limiting the usage of the new select factors to only certain plans of individual insurance, such as those without guaranteed nonforfeiture factors. They also were to consider companies using alternative possibly nondeductible reserves.

The project proceeded swiftly. Each team reported on their progress weekly for five weeks and completed their work as planned by July 31. Many contributed to these efforts. Especially noteworthy were Art Panighetti's efforts in measuring the reserve impact of various alternatives. After a series of discussions between the tax and valuation working groups, the select factors were fine-tuned any number of times. Ultimately, a recommendation that met various practical valuation objectives, as well as not changing the tax definition of life insurance, was successfully developed.

Conclusions

The revised XXX Alternative incorporates improved mortality projected to about 2000. Basic reserves will be based on the 1980 CSO tables with new 15-year select factors that grade over the next five years (20 total) to the 1980 CSO rates. The table is further limited to the full 1980 CSO rates with or without 10-year select factors at attained age 70 and above. Testing of this table confirmed that the 1980 CSO table without select factors will continue to yield the lowest reserves overall so this table will continue to be the "prevailing mortality table." This testing was done based on a present value of the change in the reserve amounts for a single year of issue at representative issue ages based on industry wide data and standards.

Deficiency reserves will be based on individual company mortality results, updated annually by the corporate valuation actuary, and as such is unlikely to have any tax effect.

Regulations defining reasonable mortality charges used in the life insurance definitional tests under code section 7702 have never been finalized. Notice 88-128 and the proposed regulations published in 1991 provide a safe harbor for rates that do not exceed those of the 1980 CSO table. The XXX Alternative is in our view wholly compatible with this safe harbor and that coupled with the other advantages of the new table, warrant proceeding with the revised XXX Alternative at this time.

One final observation, mortality has improved significantly. As a result of this improvement, it is probably time to begin development of the 2000 CSO mortality tables.

James F. Reiskytl, FSA, is Vice President, Tax and Financial Planning for Northwestern Mutual Life Insurance in Milwaukee, Wisconsin.

How to Succeed in the Worksite Market

by Alan F. Barthelman

The voluntary benefits market is growing at a rapid pace. While personal agent sales of life insurance decline, over 50% of employees would prefer to buy their benefits at the workplace, and a wide variety of benefits — homeowners, auto, life, health — are being offered on a payroll deduction basis. If the challenges of marketing at the worksite have kept your company from entering this market, you might want to consider some of the alternative approaches that are available.

Worksite Marketing, or enrollment, is a business process that depends on four key factors to assure success on a consistent basis. Whether Group or Individual voluntary products are being sold, strong performance in these four areas will assure that a high percent of employees buy your product and will continue to pay premiums because they are convinced of the value of what they bought.

The critical success factors (CSFs) of enrollment are shown in the diagram to the right. They are listed in order of increasing importance — top to bottom. And although the first three will determine the success of any given enrollment, the last will determine whether your company can manage the business effectively and keep voluntary business on the books once it has been enrolled. This article describes the CSFs. At the end, it lists some of the ways in which a smaller company with limited resources can meet these mandates for success, both for implementation and ongoing operations.

1. Onsite selling. Selling insurance requires people and relationships. In the case of worksite marketing, this is typically accomplished by enrollers conducting group meetings or one-on-ones. Without professional enrollers to sell your products to employees, you should expect results more typical of direct marketing approaches — 1–2% of people buying. The objectives of onsite selling are to

- Gain employees' trust in your company
- Give them the information they need to make an informed buying decision
- Close sales

There is a natural tendency to focus on group meetings or one-on-ones to increase participation (the percent of employees buying your product). Companies are investing a great deal in enrollers and the materials and tools that they use, because they do play a very visible, critical role. But what if your enrollers are prepared to conduct excellent meetings and nobody shows up at those meetings?

2. Enrollment process. In order to bring employees to meetings and support their buying decisions, an enrollment must be treated as a marketing *process* rather than a one-time event. This consists of pre-communications as well as support after enrollment meetings. The objectives of an enrollment process include

- Gaining employees' interest in the benefit which is being offered

- Educating employees about the need for the product
- Announcing meetings which they must attend
- Making it easy to sign up, once they've decided to buy your product

Companies that are most successful at enrollment provide a wide variety of communication tools — CEO announcement letters, newsletter articles, payroll stuffers, posters and technology such as laptop and Internet systems. However some of the best enrollment processes never get off the ground because the company's enrollment materials end up in someone's file, rather than being distributed to employees or posted on bulletin boards.

3. Employer/Sponsor Commitment. It is critical that the enrollment process which your company designs actually happens. This means that the employer — although not paying any premium — must actively support the marketing effort. The objectives here are to ensure that

- The employer follows through on the tasks required for a successful marketing process.
- The employer strongly endorses the offering to their eligible employees.

There are several ways to assess that an employer is committed to a voluntary product and its enrollment. The most common is to require mandatory employee attendance at meetings. Good project management will keep the enrollment process on track once its underway. But what if your company successfully enrolls an account but is not prepared to service it efficiently?

4. Insurance carrier commitment. Ultimately, an insurance company's level of commitment to its voluntary lines will determine its success. Excellent enrollment results will be for naught if poor service results in a coverage moving to another insurance carrier after a year or two. Service accounts well — making administration easy — and employers will stay with you much longer than for traditional products, because there is no cost to the employer. Two areas where an insurance carrier must be especially strong are:

- Administration — providing hassle-free service to the employer and employees
- Tracking and reporting — collecting and maintaining accurate data at both the group and individual level.

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How to Succeed
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Although this list of challenges may seem daunting, the increasing popularity of the worksite marketplace has spawned a wide variety of cost-effective solutions. Thinking through these alternatives and developing a cohesive enrollment strategy for your company can yield attractive results. Here are some approaches to consider:

- To avoid having to build a staff of enrollers, contract out for enrollment services or simply promote your products to producers who specialize in the voluntary market.
- When creating promotional materials or other communication tools, be sure they can be re-used in a variety of media, so your message doesn't have to be continually "re-invented."
- Be selective in what cases you will write — define your niche clearly — so that you don't incur acquisition costs for accounts that won't be profitable.
- Implement procedures that assure you have employers' commitment. They are the most important partner that you can have in marketing voluntary products to employees.
- Be sure you can service the business efficiently. If your organization is not prepared to do this, then consider contracting for services or forming strategic partnerships.

With appropriate focus, voluntary products can be very profitable business. Getting into this market should start by developing a clear strategy for your company — and then taking advantage of the many services that are available to make this strategy efficient.

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So What's New with the AOMR?

by James R. Thompson

No one's life or property are safe while the legislature is in session.

History

Currently, asset adequacy analysis is required annually only for companies with admitted assets over $500 million. Below that figure, there are exemptions based on asset size and various ratios.

In a memo of July 23, Larry Gorski of the Illinois Department of Insurance made a proposal on revising this approach. It is a complete change in that the Actuarial Opinion and Memorandum Regulation (AOMR) would not specify the detailed requirements, such as the seven scenarios. It will require the appointed actuary to opine on the adequacy of reserves based on actuarial judgment. The American Academy of Actuaries will set the actuarial standards to provide guidance. The proposal concentrates on risk profits of assets and liabilities and applies to all size companies.

The Academy believes this proposal is a "positive change in paradigm." The National Alliance of Life Companies and the National Fraternal Congress of America (NFCA) have expressed concern as to the possible cost of this proposal. We should all be watching this.

Due to new assets, Collateralized Mortgage Obligations (CMOs) and new liabilities, Equity Indexed Annuities (EIAs) for example, there has been constant talk among regulators of broadening the AOMR in various ways. Some concern was that any presence of certain products or assets should require testing. In the May 1998 issue of *small talk*, there was an article by Joel Lantzmann on modeling investments in the banking industry and how that is being simplified. It may be possible that the risk profile approach will make tools other than cash-flow testing available. Of course, it might involve more complex testing and higher cost, as the National Association of Life Companies (NALC) and the NFCA have expressed concern about. The Life and Health Actuarial Task Force (LHATF) is following this.

At a recent meeting, the members got into a lengthy discussion on the AOMR. A big issue is the state of domicile versus the state of filing. If there is a difference, which standards apply? The State Variations Task Force of the Academy evaluated four alternatives. Its memo to Leslie Jones of LHATF of August 18 outlines these. The discussion centers around the difference in valuation standards between states. It is natural that a life company should file its memorandum according to the standards of its home state. Should different standards be used for its AOMR filed in different states?

The minutes state that "no definitive conclusions were reached" but that two seemed to be the preferred choices of the members — the state of domicile plus a benchmark and the state of domicile plus disclosure. Jones said there will be further discussion as to actuarial liability for company actuaries and regulators.

Either way, the state of domicile seems to be preferred. The Academy's memo lists as least preferred the proposal of state of filing plus disclosure.

The benchmark calculation is based on codification standards. If a state of domicile is not on codification standards, the company will be required to report reserves as if it were. This would affect business sold after codification becomes effective. The Academy recommends a window period of effective dates rather than a single effective date to provide regulators with meaningful comparisons. If there is a single effective date for the benchmark, there will be differences due to different effective dates.

Disclosure applies to those foreign states that want their own laws and regulations complied with. This presumes that the appointed actuary knows that these states have different laws from the state of domicile. This requires the foreign states to make an effort to inform those companies licensed to do business that compliance is required. This takes the burden off the appointed actuary of guessing or exhaustively researching which states have which regulations.

Late Development

As this newsletter was going to print, the members of LHATF following this issue held another conference call. In it, they

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Collaborative Database Marketing

Using Technology to Know Your Prospects and Customers Intimately

by Wallace F. Dale

Insurance companies and agents are verbally accepting the challenge of this decade, "Thrive on Change," but as our industry strives to adapt to and adopt the new technologies, a legitimate question arises: "Are we really using these new tools that we and others develop to respond to our client's and our own best interests?"

> Will new technological tools change consumer insurance buying habits. . . and if so, what will we need to do to react and take advantage of these changes?
>
> Will these tools help the insurance delivery systems be more friendly, convenient and cost effective?
>
> As we attempt to meet the insurance needs of the public in a radically changed future, will we encounter an entirely different set of needs which we will be unprepared to service?

There is no question that technology will be coming at us faster than any of us can imagine. Technology will be able to respond to each of the issues raised in the questions above. The real issue is, "Will the insurance industry be prepared to respond to take advantage of technologies which are and will be available?" Unfortunately, unless drastic changes are made within the next couple of years, the answer is going to be a resounding "no."

When technology is not used properly or if it is abused, the results are not only counter-productive, they can be downright destructive with ineffective patterns repeated over and over again; junk mail that doesn't even get a second glance; telemarketers' calls that become an invasion of dinnertime privacy and our "cave" time to recharge our batteries, and now the Internet, increasingly laden with time wasters and spam. . . shortening all users' fuses.

The traditional industry standard formula for success: ten calls, to schedule three appointments, to make one sale still works in part. The three scheduled appointments resulting in one sale is still holding up well. The part that is becoming more and more difficult is the front end: the number of cold calls it takes to get a completed call made, due to factors such as voice mail, caller ID, growing regulatory restrictions, and "consumer's more fragmented schedules." Secondly, once contact is made, finding ten cold call prospects that are willing to listen to a telephone pitch is also getting much more difficult. The answer, of course, lies in making the ten calls to qualified prospects, preferably referrals, and more importantly in knowing something about each of these ten persons before a call is ever made, or being able to approach them on a favorable basis.

Not surprisingly, the LIMRA 1992 ownership study reported mounting evidence that consumers aren't overly thrilled with our delivery of life products:

- Only 39% of adults own individual life insurance.
- Only 55% of households have individual life insurance.
- In 1977, the percentage of people between the ages of 34–51 buying life insurance was 31.7%; in 1987 that had dropped to 29.5%; and in 1997, it was down to 15.8% (LIMRA 1977).
- The number of agents has decreased for five years consecutively, with retention in the field dropping from 73% after 6 months to 15% after three years.

And with record number of lawsuits filed both against agents and companies accusing both of not representing the products correctly or adequately, customer relations with both clients and prospects needs are not doing well.

Does all this mean there will no longer be the need for an agency force in the future that helps the customer navigate through the complexities of coverages and choices? My opinion is there will still be an agent involved who adds value by knowing and addressing each client's needs, desires and dreams. But, no longer will "mass-mail," "telemarketing," and "product driven strategies" dominate. Instead, through the proper use of technology, the agent of the future will be able to work much smarter and to know each customer "individually."

In the book, *One to One Future*, published by Doubleday, the authors, Peppers and Rodgers, state, "It won't be how much you know about all your customers, but how much you know about each of your customers." They also state, "The customer will direct and the marketer will respond, one customer at a time."

How do we start to build that friendly database where we know each customer intimately?

The first step is to communicate with a client in an organized way, so that we can educate, inform, present choices and help these clients navigate their financial future. The two most important categories to add to your database are voluntary information that the customer give to you and event data that triggers a change in their financial lives that creates new needs and presents new choices.

A service-oriented questionnaire that allows them to inform you would be the first step toward meeting the client's wants:

- What has been taken care of?
- What is not applicable?
- What is important?
- What is not important?
- What has changed?

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Collaborative Database Marketing
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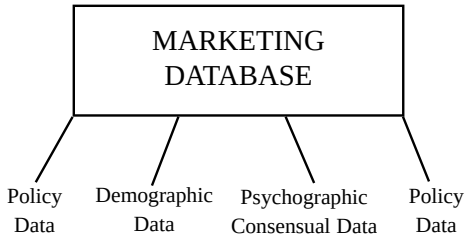
There are four legs to building the marketing database:



The key is being able to capture, store, analyze, and retrieve data for the purpose of communicating information to prospects that directly or indirectly results in sale. This communication needs to be supplied at the right time, through the right medium, at the most convenient place with the right solution. Short cut any of these and the effectiveness of the entire system is jeopardized.

The four levels of data are:

1. Operational Data or Policy Data
All information that all companies keep on name, address, policies in force, etc. This information is available, but it has to be accessible in marketing database so it can be merged with the other three legs to build the one-to-one relationships.

2. Demographic Data
Data that identifies location, income, lifestyle, age, children, and their perspective as a group. Segmenting the clients allows you to know characteristics of your database overall and where each customer fits into these segments, but it does not allow the one-to-one intimacy that the customer will expect in the future.

3. Psychographic and Consensual Data
This would include the individual wants, needs, dreams etc., that adds the intimacy that will allow the one-to-one marketing. The best way to get this is voluntarily through questionnaires, surveys, interviews, internet, faxes, e-mails. This also should include warm fuzzy value-added communications, such as newsletters, stickers, and giveaways.

4. Event Data
Marriages, births, deaths, new job, new residence, new retirement — all should trigger change in insurance needs. Much of this data can be obtained from third party vendors, but a consensual survey is still the most reliable, credible source. The event marketing is much more effective if the contact can be made prior to the event. The agent's ability to input to this system key data is crucial to the success of such a system.

Questions we should pose are:

1. Where should the database reside, when should it be updated and how can we use it to maximize the company, agent, client relationship?
2. Can we build models that we can measure and predict the success of these database marketing efforts?
3. Will this give us the answer to agent productivity and at the same time build customer intimacy?

The new technology can become the tools required to solve much of the prospecting and client unhappiness that exists today.

A recent Wharton School study suggests that less than one-third of insurance companies have studied relational databases. Now is the time to merge technology, marketing and customer service to change our current image. There is a vacuum in our insurance delivery system, and it will be filled as new systems emerge. We are moving into turbulent times and some companies will cause dust and some agents and companies will eat dust. Successful merging of technology and delivery systems, will determine who those companies are.

Some provocative questions we should ask ourselves include:

1. Are we ahead or behind the other financial services providers (banks and investment houses) in terms of technology?
2. Will other financial services or non-financial service players become serious competitors in the future?
3. Is this information revolution real, and should we be concerned?
4. What is the public's perception of our service now, and could we possibly be as vulnerable as AT&T was when long-distance service was deregulated?
5. What effect will voluntary relationship database usage have on the traditional insurance marketing approach?

For many agents and general agents, many of these ideas could be beyond their present technology acceptance level. If they wanted to know what to do to prepare for this future, the answer would be:

- Help the General Agent and his/her staff become computer literate as soon as possible.
- Start working to automate the entire Agency office operation.
- Get on the Internet and be able to communicate to your policyholders who are already there.
- Get to know your clients as intimately as possible by recording the pertinent data in a database that can be retained, recalled, massaged, and effectively manipulated.
- Help agents use this database so they can see the right prospects at the right time, conveniently, with the right products.

The insurance companies that help their agents and general agent master this process will have no trouble marketing, because the productivity and the success rate will speak for themselves. It is definitely easier to plow a field with a high-tech tractor than a mule, and technology will be just as important as the tractor as soon as we learn how to use it.

Many people reading this article will make the false assumption that because they are small and don't have the volume of customers that a major company might have, that this database marketing is not for them. There is no doubt that cost will definitely be a driving factor, but much of this work can be outsourced or handled on a local or agency basis.

The first step is obtaining hardware and software that will accommodate the data you wish to use. Almost all the software packages that I have worked with

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have the ability to customize the fields to meet your needs. The second step is to have your technology people or a data management company clean the data — correct name and addresses, and then populate it with outside information so you can profile your customers.

Based on that profile design, a collaborative service-based questionnaire should be distributed, to see which customers wish to "raise their hands," to ask for information and service. It is important to be sensitive to life cycle events that could trigger a desire on the customer's part to review their current choices. An in-house or outsourced team of database account verification representatives can call (having been invited) to discuss the questionnaire and choices available.

Normally, if we are working with an orphan database that hasn't had contact in five years, we can achieve 30% response on questionnaires and 10% new transaction purchases. The cost versus benefit analysis varies from company to company and product to product. In most cases outsourcing this work for a pilot makes the most sense unless you already have the service in place. Once the pilot is complete, it will be an easy decision to ramp up the process up or decide it doesn't work for you.

Also, since we are doing a large portion of the pre-qualification work an agent is paid to do, we often can charge them for these leads. In most cases, that charge varies between $10 and $25 per lead, and if the process is designed well they will consider this a bargain.

Benefits of a well-designed process include:

- Taking the drudgery out of the delivery of financial services
- Increasing productivity
- Reducing turnover using technology to get to know your customer one to one
- Efficiently using technology to build relationships with customers

Anticipating their expectations for the future will help position you to be the carrier or agency of choice with your present customers, and also will return to profitability the acquisition of new customers.

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So What's New with the AOMR?
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decided to eliminate the state of domicile plus disclosure. The feeling is that it would be very difficult to track all the state variations.

Larry Gorski suggested another possible approach. He pointed out that a regulator can use flexibility in accepting state of domicile. If a foreign company sells a negligible amount in Illinois, an opinion based on their state of domicile is acceptable. But if that company sells a lot in Illinois, and if their home state has a lower reserve requirement than an Illinois domestic, it will get a competitive advantage. In such a case, an opinion based on the state of filing would be required. Should there be some guidance on what additional considerations would affect which opinion would be acceptable? There will be a further report on this. There should be further discussion at the December meeting. We should all be following this to see what may happen.

If you have any opinions, let LHATF know. Contact Leslie Jones at the South Carolina Department of Insurance.

James R. Thompson, FSA, is a consultant with Central Actuarial Associates in Crystal Lake, Illinois, Editor of small talk, *and a member of the Smaller Insurance Companies Section Council.*

Worksite Marketing

by Norman E. Hill

The field of worksite marketing is growing at a fairly significant pace. More insurance companies are entering the field, and competition for agents and brokers with experience in these types of sales is becoming more intense. Worksite marketing combines features of traditional group and individual lines of business.

Definitions

In worksite, individual life and health products are sold to employees with the help of employer endorsements. At the employer's place of business, insurer representatives attempt to enroll employees for voluntary coverage. Sometimes, agents perform the solicitation themselves. On other occasions, enrollment specialists handle the process. These latter specialists may be agents receiving commissions or salaried representatives. Usually, employees pay the entire premium, although some employer contributions are possible.

Products in worksite include:

- term life
- short-term disability
- dental
- cancer
- hospital indemnity

Because this coverage is often supplemental to base group coverage, premiums per policy are usually no more than $100 per month. Lately, there has been some interest in selling long-term-care coverage on a worksite basis. For ages under 65, premiums for this coverage are significantly less than for higher issue ages.

Background

In the past, one complaint against the worksite concept was its inflexibility in employer situations. It was sometimes called a square peg in a round hole, i.e., an attempt to force individual products into group situations, while still paying higher rates of individual commissions to agents.

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Worksite Marketing
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One example of a complication involved rate increases on existing health policies. When these were billed to employers and employees, the paycheck reduction necessarily increased. This change was often not understood by employees. Sometimes, it led to loss of endorsement.

Similarly, individual lines traditionally have a fixed procedure for handling lapses. After a certain number of days from last premium payment, policies automatically lapse or convert to a non-forfeiture status. However, when employers remit premiums for numerous policies all at once, this often complicated the suspended lapse procedure.

Recent federal legislation has made worksite products more attractive. Employee coverage must now provide portability between employers. This characteristic fits right into individual products that are guaranteed renewable or non-cancelable (guaranteed premiums) to age 65 or for life. To employers, a key traditional advantage of group insurance no longer exists.

Also, some small employers have eliminated or restricted group employee benefits. This makes the idea of supplemental employee coverage, i.e. voluntary worksite coverage, more attractive.

Retention

Each month, the employer receives a "list bill" from the insurer for participating employees. Today, this is usually in electronic form. The employer checks this bill against active employees to make any corrections. Premiums are then deducted against employee paychecks. One total premium for covered employees is sent to the insurer by the employer.

Each employer is considered a worksite "case." Although individual policies are involved, the approach of looking at all employer policies as a whole is a carryover from group practice.

When employees choose to drop coverage or terminate employment, agents from the insurer attempt to retain their coverage by converting to direct billing. Often, Preauthorized Check System (PAC) monthly is substituted for payroll deduction monthly. A similar effort often occurs if the insurer loses the employer endorsement. Although unlike traditional group, this loss does not automatically eliminate inforce policies, it often results in substantial lapses.

Except for long-term care, many of the above products terminate at age 65. Since most long-term-care coverage is based on lifetime premiums, if retirees continue premiums themselves, the post retirement billing basis may have to be switched to direct bill.

Pricing and Administration

To some extent, administrative expenses for worksite products should be less than individually billed products. This is because of the mass billing process and economies of scale. However, for companies first entering the field, there will be start-up expenses for systems and related work to accommodate payroll deduction billing and suspended lapses. In addition to individual policy numbers, each policy must have an employer or case code.

Worksite commissions are usually comparable to traditional front-ended individual scales. At the same time, lapse experience for worksite products is usually worse than their individual counterparts. As a result, it should be kept in mind that a larger equivalent percentage of the worksite premium is needed to cover commissions than for individual products.

There is always the possibility of losing the employer's endorsement, and thus most covered employees. When government units are the employer, they often limit this endorsement to an annual premium bidding situation. As a result, some companies restrict worksite sales to government units. When front-end commissions are paid, companies reporting under GAAP accounting may choose not to defer them.

Systems and Underwriting

In systems, there is the need for preparing list bills to employers. Premiums receipts from employers must be allocated to individual employee policies. Some employers may be irregular in sending in list bill premiums. Many worksite insurers believe that flexibility is necessary in designing the lapse and reinstatement routines of their administrative systems.

Individual underwriting is usually required in worksite situations. Because coverage is usually voluntary, the traditional group safeguard against employee anti-selection is missing. Underwriting is often on a simplified issue, short form application basis. For cases of sufficient size and employee participation, guaranteed issue may be considered.

Several traditional aspects of group underwriting remain under worksite. To be eligible for coverage, employees must be active at work, rather than laid-off or in disabled status. Also, although not all employees are likely to choose worksite coverage, their group was not formed specifically to obtain insurance.

Complications have arisen over dependent coverage. Since some underwriting is performed, there is a question as to whether employees can sign applications for their spouses and dependents.

Conclusion

In conclusion, worksite marketing combines many considerations of both group and individual insurance. Due to changing economic conditions and statutory requirements, traditional differences between group and individual lines of business have diminished. The increasing popularity of worksite coverage represents one response to this convergence. It represents a growing field in our industry.

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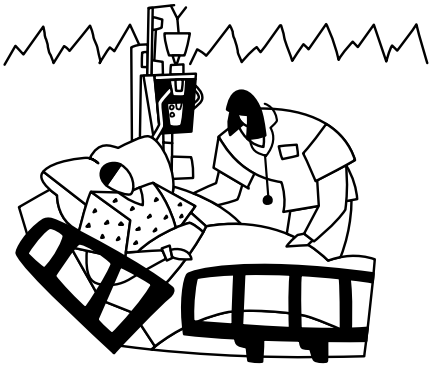
Critical Illness
The Next Great Worksite Sale

by Patrick D. Lusk



Author's Note: *The following article, adapted with permission from an August 31, 1998, National Underwriter article, emphasizes that Critical Illness insurance is potentially the next great worksite product. This knowledge must be tempered by the fact the worksite market is not easy terrain. Any carrier seeking to market insurance products through this channel must clear at least four major hurdles:*

- *The company must understand that the worksite is a niche market that demands long term focus.*
- *The company must be prepared to spend money to create the required home office systems and trained service personnel.*
- *The company must be ready to think differently about risk management. The worksite product is not a true group insurance or a true individual insurance, but a middle ground that demands new ways of thinking about underwriting.*
- *Finally, the company must appreciate the challenges of enrollment — a capability not required in either true group or individual markets but one that no worksite initiative can succeed without.*

The following account of Critical Illness product potential assumes a strong focus on the worksite market and the specific capabilities that come with that focus.

Products that meet distinct needs and are easy for sales professionals to explain invariably do better at the worksite. Among new arrivals on the scene, Critical Illness insurance best fits those standards.

Critical Illness has been a successful product for a number of years in the United Kingdom, South Africa and Australia. In these markets, it is usually an individual sale — similar in some ways to a "kitchen table" sale of individual life in the United States. The customer often has coverage in other areas, like health and life insurance. They use Critical Illness as a living benefit. It's a bridge to adapt to life challenges during and after a health crisis. They might need adaptive equipment, money to fill an income or retirement savings gap, or help with travel expenses related to treatment. Each person's situation is different. The essential need that registers with people and makes sense to them is that the lump sum payment of a Critical Illness product is going to help them get from point A to point B during a period of health crisis and recovery.

However, there is an even more basic reason why insurance to answer this need is emerging now — more people are surviving critical illnesses. About every 20 seconds, an American suffers a heart attack. We also know that stroke is the leading cause of serious long-term disability. Medical advances have improved chances for survival and quality of life for those who suffer critical illnesses. But, as more people live longer and live through critical medical events, they need financial survival tools, too. Those who are prone to save for rainy days appreciate that these kinds of events are typhoons, requiring insurance.

The word "independence" best sums up the other driver of need here. Most people have a powerful desire to be financially independent, and serious illness is usually the single most serious threat to this status. When we have surveyed consumers about Critical Illness insurance, 59% of those who had experience seeing a friend or relative go through a critical illness characterized themselves as likely or very likely to buy Critical Illness insurance. It turns out that 44 percent of those who did not have direct experience also said they were likely or very likely buyers.

There also is ample evidence that the worksite is a sensible place to deliver this product. We know from a number of different surveys that Americans look to the workplace as a source for benefits and information about benefits. Among the most likely buyers of Critical Illness products are people in low- and middle-income brackets who rely on the workplace as a benefits resource. For example, two-thirds of those in the $15,000 to $25,000 income bracket characterized themselves as likely or very likely buyers of Critical Illness insurance. About half of those in the $25,000 to $35,000 bracket said they were likely or very likely buyers.

Stand Alone and Simple

Stand Alone Critical Illness products are a good fit with workplace sale dynamics. The product, the need it answers and the fundamental terms can be explained in a short amount of time. What does this insurance do? It provides lump sum benefits for specific illnesses such as heart attack, stroke, cancer, major organ transplant and end stage kidney failure, among others. Buyers decide how much coverage to get. Benefits are paid to the insured, unless otherwise specified.

In many respects, it is like a life insurance sale, except the benefit applies to circumstances the policyholder could face personally during their lifetime. Like life insurance, it's easy to tailor to a wide range of financial profiles. The face amount easily adapts to personal budget and need, and it's easy to explain how higher face amounts result in higher premium.

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Other terms and policy provisions are fairly straightforward. It's guaranteed renewable, either for life or to a specific age. Benefits are generally level, but may reduce on or after age 65. Because it's a worksite sale, rates should be unisex. There are tobacco and non-tobacco rates, but in these days that is a very familiar concept to customers.

The single biggest objection is that the product does come with a list of specified conditions. However, with greater marketing of the product, it should become more familiar to customers that these represent the conditions most likely to create financial need. In some of the overseas markets, there has been a tendency to extend covered conditions into areas that add complexity, but don't add much value for customers. I hope that tendency is avoided in the U.S. insurance industry. Insurers can add all kinds of conditions to a product — without assuming much risk because the conditions are rare — but that does not advance meeting the core need. We know the conditions that are most likely to produce a severe financial impact and that is where the focus should remain.

The success of a related product — cancer insurance — is a good example of why focusing on fundamental need works. Holders of these policies keep them in greater numbers and are more likely to keep them even after they leave the job where they accessed the coverage. Cancer insurance also is a product where agents and carriers often hear later about the positive impact when people need the benefit. I see no reason why Critical Illness, answering a broader and related need, will not succeed similarly at the time of sale and after the sale. The need and the opportunity to explain the need in plain terms are there.

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Eager to begin work on the 1999 activities, the Smaller Insurance Companies Section Council met at 6:45 a.m. in New York. Standing—left to right—Paul Sulek, Rod Keefer, John Wade ('98 Chair), Jack McKee; sitting—left to right—Perry Kupferman, Lori Truelove, Chris DesRochers ('99 Chair).