small talk

NEWSLETTER OF THE SMALLER INSURANCE COMPANY SECTION

ISSUE 17 MAY 2001

Small Talk from the High Chair

by Edward J. Slaby

In the introductory piece I wrote for this newsletter as the incoming Chair of the Section Council, I commented on the enjoyment of actuarial work and promised to expand on this topic in a future issue. Well, time flies and the editor's memory is long, and so what follows will, I hope, redeem that promise.

Recently I was interviewed by a consultant that had been retained by our CEO to advise on the latest installment of strategic and operational planning. I knew that his major interest was in the organizational structure of the company, and, in particular any opportunities for Doing Things Differently, which is to say with fewer people. So it was disconcerting to have him ask, with his first question, whether I considered my work to add anything to the overall benefit of humankind. He was smiling as he asked this, but I was intrigued and disconcerted by his choice of question. What on earth did this have to do with anything? I replied somewhat defensively that I saw my role as a technician and manager involved with the design and management of systems to transfer and spread financial risk, etc. Later, I thought of all the clever retorts and more elevated sentiments I could have expressed, but, as usual, wit came with a lagged response.

This experience was reminiscent of a similar line of questioning. What do you do at work, Dad? Do you like it?

Let's consider this by asking the following question:

Do actuaries love their work and believe it is inherently good? Or

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Gramm Leach Bliley Survey

by Edward J. Slaby

During a recent meeting of the Smaller Insurance Company Section Council, the discussion turned to the effect of the Gramm-Leach-Bliley Federal legislation on our member companies. This bill, which became the law of the land in 1999, seemed at the time full of ominous portent for smaller size companies in the life insurance business. We decided to survey a group of people likely to have a privileged viewpoint on this issue, namely you — our membership. A survey questionnaire was prepared and placed on the Society of Actuaries Web site, with a blast e-mail sent to our membership to provide them a link to the survey response document. Your response was excellent, with 235 replies out of a universe of 660 potential responses.

As promised, here are the results of this survey. Six out of seven questions required a yes/no response. These questions are shown in the table below, followed by the percent of the responses which were affirmative. Question 3 offered a choice of three responses, and the percent of the responses for each choice is shown for that question.

Question 1

The Financial Services Modernization Act (FSMA) has removed restrictions on banks affiliating with securities firms and insurance companies. Since passage of this law has your company had or considered any proposals by banks for affiliation?

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In this Issue

From the Editor

by James R. Thompson

The bank insurance bill , Gramm Leach Bliley, or GLB, was supposed to have a major impact on insurance marketing. Has this been having any practical impact on the smaller insurance companies? Ed Slaby, the Section Chairman, has compiled the results of a survey of section members. Do the survey results match your own situation. How does GLB relate to you? Ed's "From the High Chair" confirms what we know. It is good to hear it, however.

This issue contains a lot of NAIC updates. We have highlighted various issues over the years. In this issue, we are giving some attention to credit insurance. Many small and medium-sized companies write this. We have articles by Bob Butler on the status of a new morbidity table for credit disability and by Steve Ostlund on the action at the March meeting on the interpretations of SSAP-59. Of related interest is an article by John Kerper on ancillary products sold by auto dealerships. These dealerships often sell credit insurance.

Also, there is an ongoing working group looking at the liquidity risk. Jon Niehus has a report on its progress. The proposed revisions to the AOMR are of crucial interest to smaller companies. James Thompson has an article on the latest changes and the status.

Jim Thompson

Smaller policies continue to be the object of regulatory attention. We have several articles on this, including an update on the Florida situation by Alex Zeid, as well as some comments from the most recent newsletter of the National Alliance of Life Companies. We also have a reprint from the *National Underwriter* on a background article by John Ladley.

There are some topics of general interest. Another reprint from the *National Underwriter* by Lawrence Garvey is on a new business development on standard forms. What is your opinion on the possible impact on your company's operations? How is your company on asset management? Can it be done more effectively? Are there any products you are afraid to handle because you envision the cost of asset-management to be prohibitive? Read Jay Glacy's article.

Finally we are including the NAIC cutoffs on materials for the summer meeting. Theses are important because earlier input can be included. Thus, it has more impact. In the past, people may have been missing deadlines and theses had lesser impact. Your opinion matters. If only a few people get to the meeting, they can have all these materials to refer to.

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SMALL TALK

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Small Talk from the High Chair

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even: Do actuaries feel fulfilled as men and women? Some would say that work should not be expected to be a source of fulfillment. We work to provide the means to a life, not life itself. But I have known enlightened human resources managers who recognize that we spend the majority of our waking hours somehow involved with work, and that workers should have a sense of fulfillment in exchange for this investment of time. I believe that fulfillment begins with a sense that our labors add to the overall benefit of our fellow humans. We can point to the great good done by actuaries in the invention and elaboration of the legal reserve system. This is a wonderful achievement, with many stories that are the stuff of legend in our profession, beginning with the heroic struggles of Elizur Wright, and continuing to our day in the judgment calls made by Valuation Actuaries who annually do an asset adequacy analysis of their company's reserves. This system, now elaborated to keep up with new financial products and increased investment volatility, has been an actuarial triumph. And every practice area — pension, health insurance and others — has its own counterpart to this system, and its own lore and heroes. We carry this torch to the next generation. Long may it burn!

On an everyday level, what is the nature of the actuarial experience? What is it like to be an actuary now, at this time? A number of years ago, I attended a meeting of a local actuarial club in the Southern city where I lived and worked. I recall the fulminations of a retired member, a former officer of our Society, who railed against the materialists who were taking over the insurance business. I suppose he meant businessmen who were primarily profit driven, as compared to the folks who ran the evangelical insurance organizations he remembered from his actuarial youth. I mention this simply to highlight the fact that this business has undergone and survived many changes, both external and internal, and it is the destiny of each generation of actuaries to cope with the changes that come their way, as they have for so many ratebooks. With these changes comes uncertainty, but also, as compensation comes, the opportunity to be creative, which I propose is the main delight of our work, or any work. Every day, we are blessed with situations that engage our creative faculties, and the creativity we apply to solutions is the most important contribution that we make to our employers.

> ***"I believe that fulfillment begins with a sense that our labors add to the overall benefit of our fellow humans. We can point to the great good done by actuaries in the invention and elaboration of the legal reserve system."***

We should be mindful of how much fun we are having in our work. We can be gratified by the important contributions that we make for the welfare of society. We are constantly challenged by important problems and need to use all of our creative abilities to effect solutions. And we're paid well, in addition!

The young actuaries that I know have a lot of enthusiasm and pride in their work, and have the same craving for achievement that has always characterized this profession. They can be confident that actuarial work will continue to be a source of enjoyment and satisfaction to its practitioners.

You see, my daughter, I find ways to keep promises. And I do like my work. A lot!

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Gramm Leach Bliley Survey

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Yes	52%
No or no response	48%

Question 2
The FSMA introduced federal regulators into certain types of insurance operations. Has your company had any interaction with federal banking or insurance regulators?

Yes	51%
No or no response	49%

Question 3
The FSMA created stringent privacy and consumer protection requirements. Have these resulted in any of the following reactions by your company?

Very urgent activity	37%
Limited activity	43%
No activity	20%

Question 4
Has the FSMA changed the strategic planning or direction of your company?

Yes	59%
No or no response	41%

Question 5
Is your company currently an acquisition target, or do you expect to be a target in the foreseeable future?

Yes	37%
No or no response	63%

Question 6
Has the passage of the FSMA created any increased competition or contraction of your company's market share?

Yes	69%
No or no response	31%

Question 7
Do you perceive the FSMA as creating organizations which are too large to be efficient?

Yes	53%
No or no response	47%

While not intended to be scientific, this survey nevertheless does allow us to discern some general trends and effects on the Section membership.

Questions 1 and 2, for which the responses are highly correlated, indicate a fair amount of activity by either banks or insurers to investigate strategic combinations. At the SOA Annual Meeting in New Orleans, the Section will sponsor several lively programs for actuaries in smaller companies and their consultants. I hope we can hear from some of you how bank affiliation has worked for your company. Both success and failure experiences should be very instructive.

Question 3 responses indicate that the new privacy regulations are keeping a lot of us quite busy. I hope we get an opportunity to hear about some of your experiences with this issue. Is there a newsletter article waiting in the wings?

Question 4 responses show that smaller companies are generally rethinking their vision and mission statements, and are actively involved with an examination of their markets and business niches. Some would say this is a predictable response, but I'm not so sure that it is.

Question 5, on the other hand, reveals a relatively low level of takeover anxiety among the membership. If this is so, and I believe it is, it deserves further examination. Ostrich-like lack of concern? Or a reflection of a view that banks do not really want to be in the risk underwriting business.

Ed Slaby

Question 6 is likely correlated with Question 4, and reflects the increased focus that companies must have to succeed in current business conditions. This is another topic that deserves informed discussion by our membership.

Finally, Question 7, which betrays a small company bias in its phrasing. About half of the responses were supportive in their opinion that larger is not necessarily better. The issue is not simply scale versus flexibility and agility. There is room for both kinds of companies. But we should consider whether this legislation, and all that proceeds from it, tilts the advantage to the larger companies.

These responses have drawn, in very broad strokes, a picture of the new forces that are impinging on the smaller companies, and on all of us in our day-to-day work. We'll be digging into these topics in the sessions we sponsor at upcoming SOA meetings. Join us for the discussion. Send a letter to the editor of this newsletter. Let's keep this conversation going. And thanks for the great response.

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BREAKING NEWS — LEGISLATION INTRODUCED TO RESTRICT SMALL POLICIES

Editor's Note: The following is reprinted with permission from the NALC (National Alliance of Life Companies), *an Association of Life and Health Insurance Companies' newsletter which ran in the March 31, 2001 issue.*

Senator M. Mandy Dawson (D-30 th) has introduced SB1786, which would greatly restrict the sale of small policies and ban the sale of Industrial Life. The bill would make the following changes to the current code:

1. Each insurer who has in force in Florida, a policy of life insurance with a death benefit of $15,000 or less shall annually on the policy anniversary date, by United States mail, disclose to the policyholder or premium payor the total amount of premiums paid, the cash value, and the amount of the death benefits payable under such policy. If the insurer is unable to locate the policyholder, the policyholder shall be converted to a full paid-up status. A disclosure notice is not required to be sent for any policies that are in full paid-up status or policies that are converted to full paid-up status.
2. Any changes to the code would not be effective for policies written prior to July 1, 2001.
3. For all policies issued after July 1, 2001, with a death benefit of less than $15,000, the following would apply:
    a. When the cumulative premiums paid exceed 250% of the death benefit, the insurer shall enhance the death benefit by $0.50 for each premium dollar paid in excess of 250% of the death benefit.
    b. When the cumulative premiums paid exceed 500% of the death benefit, the insurer shall enhance the death benefit by $1.50 for each premium dollar paid in excess of 500% of the death benefit.
    c. Industrial life insurance would be prohibited and such policies may not be delivered or issued in Florida, on or after July 1, 2001.
    d. Each insurer who has in force in Florida an Industrial Life policy, shall annually, on the policy anniversary date, by United States mail, disclose to the policyholder or premium payor, the total amount of premiums paid, the cash value, and the amount of the death benefits payable under such policy. If the insured is unable to locate the policyholder, the policy shall be converted to full paid-up status. The disclosure notice is not required to be sent for any policies that are in full paid-up status or policies that are converted to full paid-up status. We will watch this matter extremely closely. The NALC is seeking help and input from all Members concerning this matter. **If you are interested in participating in the work on this matter, please contact Scott Cipinko (*Cipinko@nalc.net*) immediately.**

SMALL POLICY WORKING GROUP SHIFTS FOCUS

The Small Face Amount Working Group met in Nashville Tuesday. The Co-chairs are Commissioner Mike Pickens (AK) and Director Ernst Csiszar (SC). The Working Group decided to limit the inquiry of the Working Group to disclosure at the interim meeting in Atlanta in February. Commissioner Csiszar advised that the industry has been asked to provide a study concerning small policies. The study has now been broken into two parts. The first part is an economic study, which will be conducted by Professor Michael Porter of Harvard University. The second study concerns how the policies are written. That will be an educational piece created by the American Academy of Actuaries (Academy). The Academy will give its report to the Working Group when it is completed. However, it was originally intended that the economic study would be presented to the Life Insurance and Annuities (A) Committee at a later date, as the study would be completed after the June deadline for the completion of the Working Group's work. Commissioner Csiszar stated that there are two fundamental issues that need to be addressed. The first issue is whether the industry is garnering excess profits. The second issue is how smaller policies are priced. In addition, there is a question about discriminatory practices in connection with mode of payment. Additional discussion took place concerning how the Academy will conduct its study. Director Nat Shapo (IL) advised that he has problems with the concept of strictly moving toward disclosure as a solution. Rich Robleto (FL), who is very well aware of the Florida legislation, was confused about the direction of the Working Group. Mr. Robleto thought that the group was working toward disclosure regulation. He was also concerned about the value of any study. He would like to see all insurance companies included in the Academy study if it would not include the companies on the fringes of the industry, which may be charging excessive rates. This issue came up in connection with the discussion of the Academy study in detail by Mike Pressley, Vice President of the Academy. John Hartnedy (AK) wanted to make clear that the Academy is a truly independent organization, which includes regulators and members of the industry in its membership. Because the academy will do the study based on broad averages, the top and bottom companies may not be included. Further, the study will be a blind study.

The companies in the study must be anonymous in order to avoid any claims of restraint of trade. Further, the academy must be aware of antitrust concerns. Commissioner Merwyn Stewart (UT) stated that most of the industry is doing a reasonable job. However, as some are not doing a reasonable job, it is important to see how those companies are operating. He emphasized that the regulators want the industry to make reasonable profit and for consumers to get good value. If both of these things occur, it will be a better world. Mr. Pressley advised that the study would not reveal which companies are making a profit. Leslie Jones (SC) advised that the study would show scenarios were premiums exceed the face amount. A number of regulators asked questions about how the study would work. This led into the discussion of specific questions. A number of questions were prepared by Mr. Hartnedy and Ms. Jones. The industry and regulators will be asked to respond to the questions by April 20, 2001. The conference call will be held at that time and more questions will be drafted. In addition, an interim meeting will be held during the week of May 7, 2001. The most likely location for the next interim meeting will be Atlanta. Paragraph copies of the questions are available from the NALC office or by contacting Scott Cipinko (*Cipinko@nalc.net*).

small Face Amount Policy Legislation

by Alex Zeid

Some states are considering legislation to correct perceived abuses in the small face amount market. For example, one bill recently introduced would have required an annual policyholder notification with the policy becoming fully paid up if the policyholder could not be located. It also would have required benefit enhancements of certain types of policies if the premium payments reached certain levels. Finally, the bill would have prohibited the delivery or issuance of industrial life insurance policies after a specified date.

We believe that adoption of these requirements would actually hurt consumers because the availability of small face amount insurance could be greatly reduced. Even if carriers continue to sell such policies, costs are likely to increase significantly as a result of the additional mandated death benefits, higher administrative expenses and potential fraudulent activity that will result.

Paid-Up Benefits

One proposed bill (Florida Senate Bill 1786) states that each insurer with an in-force policy of $15,000 or less must annually disclose the cumulative amount of premiums paid, the cash value and death benefits available. If the insurer is unable to locate the policyholder, the policy must be converted to fully paid-up status. This provision could lead to significant fraudulent activity if policyholders decide to make it difficult to be contacted soon after purchasing coverage, leading to automatically paid-up policies and ultimately resulting in higher premiums for those policyowners who continue to allow themselves to be found. The administrative costs of tracking down policyholders could become excessive. We are assuming that, in this context, "fully paid-up" means the full policy face amount is paid up, not the amount of reduced paid-up insurance as required by the Standard Nonforfeiture Law. In addition, the Florida bill would discriminate against the policyholders with face amounts exceeding $15,000 since this provision would not apply to them (leaving them without paid-up policies under these circumstances or the disclosure).

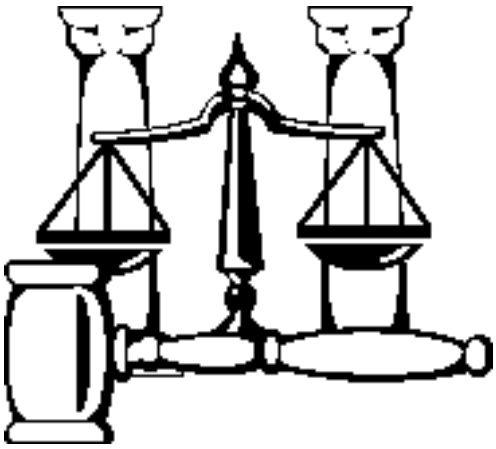
The bill is silent about the effect on policy reserves when a policy becomes fully paid up. Current in-force policies were not priced for this type of benefit, and reserve increases could result in solvency problems. It is obvious that this provision is unsound, and that there is no logical reason for providing such benefits, and it does not add anything to the Standard Nonforfeiture Law whose intent was to guarantee that policyholders receive an equitable value in the form of reduced paid-up insurance or extended term insurance whenever termination occurs, for whatever reason it occurs.

Benefit Enhancements

Florida Senate Bill 1786 would have specifically required, for policies issued after July 1, 2001 with a death benefit of $15,000 or less, the following:

- When the cumulative premiums paid exceed 250% of the death benefit, the insurer must enhance the death benefit by $0.50 for each premium dollar paid in excess of 250% of the death benefit.

- When the cumulative premiums paid exceed 500% of the death benefit, the insurer shall enhance the death benefit by $1.50 for each premium dollar paid in excess of 500% of the death benefit.



As a result of our testing, we have concluded that such benefit enhancements would drive up prices significantly on products designed to meet these requirements. Products that include the proposed enhancement provisions would be difficult to price, since benefits are tied to the premium. This type of benefit is a more complex and less understandable variation on the return of premium benefit provisions found in some policies.

Return of premium benefits result in significantly higher premiums, particularly for smaller policy sizes and at older ages. There would also be additional costs to the insurance company as a result of the need to price new products with the new benefit provisions, develop and file new policy forms and calculate new cash value and reserve factors. We do not believe that insurers could have had new products and administrative systems in place for a July 1, 2001 effective date. For small companies, these costs may make selling these products prohibitive resulting in reduced availability of these policies to the consumer and less competition in the marketplace.

Another consideration that is not being taken into account is that the policyholder has often accrued a significant cash value by the time the premiums exceed the current death benefit. This

accrued value is a real, tangible benefit that should be considered as an offset to any perceived losses from the accumulated premiums exceeding the current death benefit. If a policyholder decides that he no longer needs the death benefit coverage and surrenders the policy, the net payment equals accumulated premiums less any cash value received. Indeed, as premiums increase due to issue age, the corresponding cash values also increase.

We calculated premiums with and without the enhanced benefit option and found that the enhanced benefit option would increase prices to a greater extent as the issue age increases, thus harming the older consumer. Extremely large price increases would occur at the oldest ages where premiums are already necessarily high due to age. These older consumers often have no other available insurance alternatives because of underwriting considerations and the lack of term insurance availability at these ages.

In addition to making the policy more expensive, we found that the enhanced benefits actually would cause the perceived problem to happen at younger issue ages than it otherwise would have: in other words, the increase in the premiums necessary to produce the enhanced benefit would result in premiums exceeding death benefit that much more quickly. It would be a vicious cycle.

In addition to the costs of repricing and implementing new products, the administrative costs associated with this type of benefit would also be significant, particularly in light of the complexity of the calculations that would be required on an individual policy basis. Since the death benefit is directly related to premiums paid (an amount which may include varying premiums for riders and policy fees), death benefits can no longer be calculated from pre-calculated tables of values that are stored on the administrative system. Instead, death benefits would have to be calculated and stored for each individual policy. This would require a major upgrade to administrative systems or have to be done by hand. The alternative would be for companies to eliminate or significantly restrict the availability of supplemental benefits and riders and to create complex, non-policy fee banded premium rate structures, which would also increase costs and reduce value to the policyholder.

We believe that there are sound actuarial reasons for life insurance policies to have cumulative premiums that exceed benefits paid in later years. For those unfortunate individuals who die in the early policy years, they receive more in benefits than were paid in premium. On the other hand, those who survive pay for these early death claims and may ultimately pay more in premium than they receive at time of their death. This is fundamental to any risk pooling concept. This does not mean that these policies do not provide value to the consumer.

"The best time to make sure that a policyholder understands what he is buying is when he is buying it."

Indeed, the basic tenet of any kind of insurance is that you pay a premium for something that you hope you won't need to collect on. By its very nature, whole life insurance will provide benefits in excess of collected premiums to some insureds *and* will also collect premiums in excess of benefits from other insureds. The key to making sure that the consumer receives sufficient value is to make sure that he or she understands this tenet and takes it into consideration in the purchase decision.

Conclusion

We understand the concerns being expressed about policyholders who may purchase life insurance policies and later feel that they did not receive the value that they paid for because they didn't die early. When that misperception occurs, it is not good for anyone involved.

However, the approaches being considered by some regulators are not only an unreasonable burden on the carriers who sell policies in this market, but they are also ineffective and unnecessary ways to address these concerns. The ultimate result would be the inability of insurers to provide these small policies to those who need the protection the most, i.e. those who are unable to afford larger insurance policies due to financial, age, or health limitations.

The best time to make sure that a policyholder understands what he is buying is when he is buying it. That is when the policyholder can and should make decisions whether or not to purchase a policy or to use his "free look" provision to return a policy. For most small policies, the relationship between premiums to be paid and benefits payable over the life of the policy, at least on a guaranteed basis, are easily determinable at issue.

Attempts to solve what is essentially a disclosure problem by adding an expensive layer of hard-to-understand post-issue disclosures and complicated, hard-to-understand mandated future benefits are not reasonable remedies, but would actually hurt those that the regulators seek to protect.

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Outsourcing the Investment Function: *Opportunities for the Smaller Insurer*

by Anson J. Glacy, Jr.

Editor's Note: This report has been prepared from original sources and data that we believe to be reliable, but we make no representations as to its accuracy, timeliness, or completeness. This report is published solely for informational purposes and is not to be construed as an offer to sell or the solicitation of an offer to buy any security. Please consult with your investment professionals, tax advisors, or legal counsel as necessary before relying on this material.

Smaller insurers, while frequently blessed with nimbleness and clarity of vision, nevertheless face long-standing obstacles to success. Chief among these is competing with the critical-mass efficiencies that their larger brethren enjoy in product sourcing and delivery and in investment activities. However, recent events have put large-scale economies within grasp of many small companies, especially in the area of investment management, and have brought "large company" service and performance standards to the smaller insurer. This article briefly surveys some of the technological advances that have powered this revolution and identifies the benefits that small companies are realizing because of it.

Notwithstanding recent unpleasantness in the stock market, the "New Economy" truly has had a democratizing impact upon the distribution of information and the ability of companies large and small to conduct business from afar. New technology has permitted small insurers to "level the playing field" in a number of powerful ways. Certainly the Internet has revolutionized the distribution of insurance product, constituting an empowering force for insurers without entrenched (and costly) "bricks and mortar" distribution systems. Accounting and administrative packages, previously available only as big-ticket systems outlays, now see their functionality commoditized and broadly disseminated through both the Internet and company intranets. These trends relentlessly force down the cost of underwriting, issuing and maintaining an insurance policy and of providing timely, relevant and reliable information for managerial decision-making.

"Certainly the Internet has revolutionized the distribution of insurance product, constituting an empowering force for insurers without entrenched (and costly) 'bricks and mortar' distribution systems."

The ASP Phenomenon

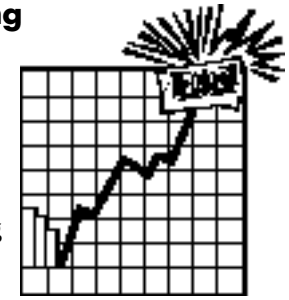
Such technological advances have not been absent on the asset side of the balance sheet. Technology has brought a level of immediacy and pervasiveness to market information that enables small insurers to maintain intimate monitoring of asset performance. No longer does a small company only get a look at asset transactions and performance on paper reports six weeks after the close of the quarter. Much of this benefit derives from the explosion in the use of Application Service Providers (ASP). ASPs spare users the time and expense of procuring or developing their own computing infrastructure for trading, analytics,and reporting. Instead, users access computing resources through the Internet that have already been established at a convenient network location and manned by a team of experienced specialists. This approach, therefore, affords the small insurer the opportunity to purchase economically priced functionality slices, not an expensive, full-fledged system.

Most noteworthy is the rise of ECN-based electronic exchanges like Island, a unit of Datek Online Holdings, and Instinet (from Reuters). These are computer trading systems that automatically link buyers with sellers. For small insurers, they represent a powerful means of reducing commissions and eliminating gaping bid-ask spreads that are typically gobbled up by marketmakers. While the fixed-income universe has lagged in moving to electronic exchanges, a number of initiatives are under way to extend these cost-saving benefits to bond investors. And a consortium of twenty-three leading derivatives dealers, like J.P. Morgan Chase, Goldman Sachs, and Deutsche Bank, are establishing SwapsWire, a common Internet protocol for electronic trading of interest-rate derivatives.

Advances in Securitization

Securitization is the process of repackaging financial assets into securities, generally from less liquid forms into more liquid forms. Mortgage-backed securities and collateralized mortgage obligations are examples of securitization in action. These instruments repackage residential mortgage loans, and in doing so, bring valuable liquidity to the mortgage markets and allow investors to more easily participate in this asset class. (The insurance industry traditionally has securitized policy loans or future surrender penalties as a way of increasing financial flexibility and efficiency.) Recently, this practice has been extended to the high-yield bond markets. Historically, smaller insurers have been unable to effectively gain exposure to the high-yield markets due to the twin obstacles of odd-lot trading costs and inability to diversify. A collateralized bond obligation (CBO) pools a large number of high-yield bonds in order to gain the benefits of diversification, then securitizes them into tranches of various seniority and credit quality. For example, an equity tranche absorbs initial losses, followed by a mezzanine tranche and finally a protected senior layer. Small insurers then can purchase these conveniently sized securities according to their particular tastes and capacity.

Investment Management Outsourcing



While executives at small insurers often possess considerable investing expertise and savvy, seldom is it economical for these companies to retain the investing function in-house. Beyond the economies of scale to be realized by outsourcing nuts-and-bolts activities like accounting, regulatory compliance, and trade execution, full-service external investment managers can deliver:

- Assistance with investment policy development, including guidelines, limits and control procedures
- Access to specialty asset classes, like convertible bonds and asset-backed securities, that can add valuable punch to a small insurer's core holdings
- Advanced asset/liability expertise and advice, a critical ingredient for prudently balancing risk and return
- Sophisticated asset allocation technology to support strategic and tactical portfolio actions
- Access to deal flow typically available only to large institutional investors
- The ability to perform cash flow testing and other risk assessment exercises required by regulators

Thus, through outsourcing of the investment management function, smaller insurers can effectively and economically harness the market coverage, trade execution efficiency, and performance attributes of an experienced asset manager.

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The Other Insurance Products Auto Dealers Sell

by John H. Kerper

Unless you live on Mackinac Island, you've bought a car or truck and been through the one-two sales punch of the car salesman and the finance and insurance (F&I) department. What started as an auto purchase may end up as the purchase of credit life and disability insurance, a vehicle service contract, gap insurance, special financing, undercoating, and other products in addition to the auto. The auto dealer is interested in selling more than autos and for good reason. These extras produce more than half of their profits from auto sales, and insurance sales are a significant source of these profits.

An insurer able to offer the full range of insurance products that an auto dealer sells may have an advantage in getting and keeping the dealer's business. Many small life insurance companies underwrite credit life and disability insurance, and most life actuaries are familiar with these products. Those that have a casualty affiliate may also underwrite vehicle service contracts (VSC) and gap insurance. If a company is in this market, but does not have these casualty products in its portfolio, should it add them? Before answering this question, let's examine the basics of these products.

VSC Basics

VSCs are a contractual promise to repair certain mechanical breakdowns which occur during the contract term. Coverage may be limited to a few component systems (e.g. engine and transmission) or may be "bumper-to-bumper" — covering everything except certain excluded items. A breakdown is defined as the failure of a covered part to perform its function. Some contracts define breakdown as the failure of a covered part to perform within the manufacturer's specifications. Either definition also includes a list of what is not a breakdown. This list usually includes regular maintenance, body and interior damage, failure caused by a pre-existing condition (used cars) or lack of proper maintenance as prescribed by the manufacturer, and failure due to property damage (storm, collision, fire, etc). There is usually a deductible of $50 – $200 per claim, although some VSCs charge a separate deductible per component system involved in the claim. Many insurers also offer a disappearing deductible option which waives the deductible if the vehicle is brought back to the selling dealer for service.

The contract term for a VSC can run from 1 month to 84 months. For new vehicles, the term generally runs for a specified number of years from the in-service date or until the odometer reaches a specified mileage, whichever occurs first. Some providers will extend the calendar portion of the term from the VSC purchase date rather than the in-service date for nearly new vehicles — used cars still under the manufacturer's warranty. The typical new car contract runs 5-7 years and for 60,000 to 100,000 miles. The term for used vehicles is the lesser of a specified number of months and miles from the VSC purchase date. The most common terms are for 12, 24, 36, or 48 months with the mileage term at 1000 times the number of months.

"The auto dealer is interested in selling more than autos and for good reason. These extras produce more than half of their profits from auto sales, and insurance sales are a significant source of these profits."

Most VSCs are sold for a single fee, which is either paid or financed during the vehicle purchase. Refunds are calculated pro-rata based on remaining months or miles of coverage, whichever is less. The price charged by the dealer is made up of three components — (1) insurance premium paid by the obligor, (2) administrative fees, and (3) dealer markup. It's important to note that the total price charged is unregulated in most states. It's also important to note that component (1)

is the only portion that is paid to the insurer. Components (2) and (3) are not paid to the insurer, nor are they included in premium for purposes of calculating premium tax or risk-based capital. The reason the total fee is not included in premium is that the actual service contract is not an insurance contract. Either the auto dealer or the claim administrator buys the insurance to cover its obligation under the contract.

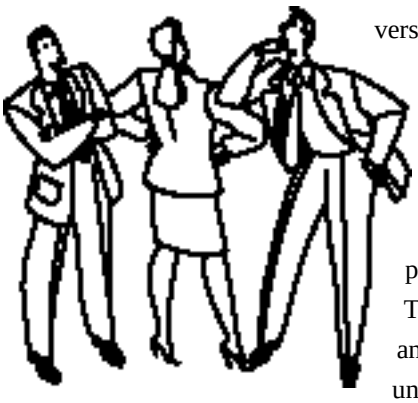
Gap Basics

Gap covers the shortfall between the loan payoff and the book value of the vehicle

or insurance recovery (depends on contract) in case the vehicle is declared a total loss from either physical damage or theft. Most contracts cover all or some of the property insurance deductible and may cover one or two delinquent payments. Some contracts even offer a new car purchase allowance if the insured returns to the selling dealer to buy a replacement. While the term for gap coverage matches the term of the loan, the possibility of a claim is zero, once the book value of the vehicle exceeds the loan payoff.

Like VSCs, the fee for Gap is paid at the time of purchase. The refund method varies by state, with most allowing a rule of 78s amortization due to the declining value of the coverage, but some (e.g., Texas) require pro-rata. Coverage may be offered as a waiver agreement or as an insurance contract to the purchaser, depending on the state. Waiver coverage is similar to VSCs where only a portion of the charge is considered premium and the total charge isn't regulated. Insurance coverage is similar to credit life where the entire amount is the premium and the total rate may be regulated.

Should a Small Insurer Offer These Products?



That's a good question. It is possible to make a good return selling VSCs, but it takes tens, or hundreds, of thousands of contracts and several years of paying claims on those contracts to develop enough experience to confidently rate this business. It also takes an experienced claims administrator that shares in the gain and pain of good and bad results to ensure that the insurer has a fair chance of making a profit. One way to enter this market with less risk is to collaborate with an established insurer that has an in-house administrator for VSCs and a history of profits in this market.

Another possibility is to mimic the manufacturers' extended warranty programs. Under the assumptions that the manufacturers' have adequate experience and are trying to make money, their rates are a reasonable starting place for a new VSC insurer with no experience. Still, a trusted administrator is needed. Hire experienced personnel and start slowly.

As for Gap, this business is relatively immature, but highly competitive. The relative immaturity shows in the simplicity of the rate chart of most carriers. The risk of claim depends on the length of the loan because a longer term leads to a slower decrease in the loan payoff value and a larger gap for a longer period. Also, if the resale value of a vehicle drops relatively quickly from the purchase price, this drop leads to a greater exposure to claim. However, most carriers currently offer the waiver version of this product at a single rate for all terms and vehicles, and the common rate that is charged for this coverage is so low that the profit potential is very limited. This is a product to watch and possibly find a partner to underwrite.

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Small Policies = Big Controversy

by Jack Ladley

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

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

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

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

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

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

Who is Affected?

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

Jack Ladley

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

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

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

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

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

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

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

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

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

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

Defining the Problem

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

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

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

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

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

Potential Solutions

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

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

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

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

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

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Gramm Leach Bliley Survey

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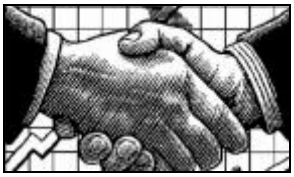
some time to analyze and would have an undesirable financial impact on many companies.

Toward a Compromise



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

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

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

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

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

Questions On The Issue

- How can it occur that after a number of years, the total premiums paid on these policies exceed the face amount, and how can this be explained rationally to inquiring insureds?
- How frequently are carriers offering volume discounts for multiple policies or more efficient premium modes?
- Are claims being paid on multiple policies when a claim is filed initially on just one of those policies?
- Why do premiums differ so much, even for the same company and same basic policy form, as has been shown in some comparisons, even if premium differentials usually are linked to differing underwriting that may range from preferred to guaranteed issue?
- Is there a remedy in cases where the death benefit on a policy is now greatly exceeded by the inflating costs of funerals?
- What is the persistency experience on SFAPs in various segments and how can it be improved? What causes a high lapsation rate in some segments?
- Does agent fraud occur with SFAPs and, if so, how can it be prevented?
- Should agents or companies generally be required to provide more information/ disclosure on costs of SFAP and available options?

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Life Liquidity Risk

by Jon E. Niehus

At the recent NAIC spring meeting in Nashville, the Life Liquidity Risk Working Group met. This working group, chaired by Mike Boerner of the Texas Department of Insurance, reports to the NAIC's Life Insurance and Annuities (A) Committee. This working group is continuing to review issues in connection with the liquidity of insurance companies and may complete its work by the end of the year. The major focus of its efforts is to investigate sources of liquidity risk and risk management practices, which may help to alleviate that risk.

The Life Liquidity Risk Working Group is closely related to the Life Risk-Based Capital Working Group. In a December 2000 report, the working group indicated that it would (1) discuss with the Life Risk-Based Capital Working Group the appropriateness and reasonability of adding a charge for liquidity risk to the formula in order to discourage excessive amounts of liquidity risk from being taken; and (2) research whether and how liquidity risk impacts risk-based capital requirements for other financial intermediaries.

Concerns about modeling liquidity risk date back at least ten years. The Society of Actuaries published a *Dynamic Financial Condition Analysis Handbook* in May 1996. However, the recommendations contained in this document have not been widely adopted. Although the RBC has been used for several years now, it is a static formula that could be improved. Regulators believe that the recent modification to the C-3 (Interest Rate Risk) component is a step in the right direction. For several years some rating services (*Best's and Moody's*) have been requesting supplemental information from companies writing certain product lines to assist in evaluating liquidity risk.

The Life Liquidity Risk Working Group arose from an interest in liquidity matters in 1999 by the Life and Health Actuarial Task Force relative to guaranteed investment contracts with bail-out provisions with increased interest subsequent to the General American insolvency. The working group was formed to consider and make recommendations related to products issued by life insurers that have significant liquidity risk (e.g., GIC's with bailout provisions). Areas to be considered include, but are not limited to, appropriate limits on the level of activity by insurers, required and/or prohibited contractual language, reserving methods, reporting requirements and risk management systems for insurers engaged in this activity. The working group is studying whether changing the RBC formula can adequately reflect liquidity risk or whether actuarial modeling needs to be incorporated.

The working group is reviewing work done by banking regulators and by insurance regulators in Canada. The working group has been studying a handbook released in February 2001 by the Office of the Comptroller of the Currency to provide guidance to help examiners and banks understand and manage liquidity risk. The press release announcing the handbook states, "The handbook recommends that bankers use their contingency funding plan (CFP) to integrate liquidity analysis into the day-to-day liquidity management process. The CFP can assist in identifying an appropriate amount of liquid assets, measuring and projecting funding requirements during various scenarios, and managing access to existing and alternative funding sources. The

handbook also advises bankers to evaluate liquidity risk from a number of perspectives, using tools such as a rollover report to identify significant maturity gaps and a funding concentration report to identify changes in significant funds providers." The complete text of this 86-page handbook can be downloaded from *http://www.occ.treas.gov/handbook/liquidity/pdf.*

It appears that the efforts of this working group could result in a significant broadening of the responsibility of the Valuation Actuary. The current Actuarial Opinion deals only with reserve adequacy. Liquidity risk deals with capital adequacy and company solvency. Small companies that fought against the expansion of the Actuarial Opinion and Memorandum Regulation may have only been seeing the tip of the iceberg. Regulators are deeply disturbed and embarrassed by company insolvencies especially of major companies. The issue of liquidity risk is unlikely to go away. For additional information, please contact me by telephone at 800-308-2672 or by e-mail at *jon_niehus-fmsi-actuaries.com*

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Standard Forms Could Bring Life Insurers Big Savings

by Lawrence Garvey

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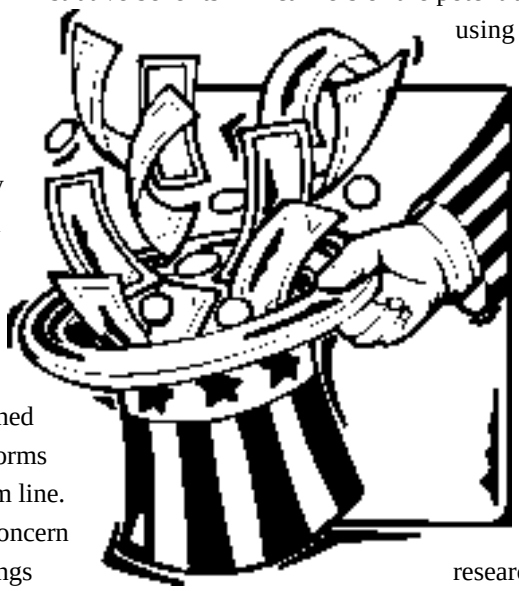
"Money talks." That's the most common response received from life insurance carriers when they are presented with the idea of adopting standardized life insurance forms.

Agents see the administrative benefits and advantages of multiple carrier submissions. Solution providers see the idea as a way to streamline system development and cross-sell to both carriers and agents.



Carriers, however, are concerned with how standard forms will affect the bottom line. The answer to this concern is that potential savings could total hundreds of thousands of dollars per company per year.

These savings include a reduction in costs associated with distribution, research and development, compliance, as well as the reallocation of corporate resources. In addition, carriers who utilize standard life insurance forms can expect to see their expenses associated with entering new markets substantially reduced.

To those in the property and casualty industry who have been using standardized forms for over 30 years, the idea of standard life insurance forms seems like a natural progression. P&C carriers have been saving money, so the savings no longer surprise them.

To life insurance carriers, however, the idea is radical and often viewed with skepticism. Life carriers want to be convinced that standard forms will bring measurable, substantial savings. Unfortunately, trying to convince life carriers of the potential savings by using P&C numbers is no easy task.

There is, however, light at the end of the tunnel. ACORD has made a commitment to the development and implementation of standardized life insurance forms. We have researched and studied the issues and identified the potential savings as well as the business benefits that carriers will realize in supporting and adopting these forms. We have also put to rest some of the industry myths that some have used to try to impede the introduction of standard forms.

From a financial perspective, the potential savings are enormous. As the life insurance industry moves into the electronic age, the cost of information exchange has become a central issue. By migrating to standard forms, life carriers will be positioning themselves to capitalize on the many emerging technologies of today's rapidly changing landscape, and the savings and business opportunities these technologies present.

In addition, a company that migrates to standardized life insurance forms can expect to save hundreds of thousands of dollars annually in the more traditional costs associated with forms development and distribution. Tangible savings will include cost reductions in filing fees, staffing allocation, and litigation exposure as well as distribution expenses.

In costs associated with traditional form development alone, the average life insurance carrier can expect to save upwards of $300,000 annually, and this number does not include litigation exposure or distribution. Add this to the explosive expansion possibilities that standard forms present a carrier in the e-commerce arena and the decision becomes a "no-brainer."

Contrary to what was conventional wisdom a few years ago, the life insurance industry is not currently on the verge of a paperless revolution. Life insurance carriers must find a way to integrate new electronic technologies — and the financial incentives they present — with more traditional, time-tested, paper-based methods of doing business.

This balance is critical to a company's commitment to maintaining their conventional market share and to the exploitation of emerging markets.

"Technological integration will be a major challenge for carriers. Carriers see the financial benefits of adopting new technologies, but have not yet figured out how to do so without upsetting their current distribution practices."

Theoretically, virtually every carrier in the industry has made this commitment. However, practically only a few have actually begun to address this commitment with concrete steps and objectives. There is a very real gap between what carriers know has to be achieved and how to go about achieving it.

Technological integration will be a major challenge for carriers. Carriers see the financial benefits of adopting new technologies, but have not yet figured out how to do so without upsetting their current distribution practices.

Standard life insurance forms allow for paper-based transactions while standardizing the information being collected and therefore making electronic delivery much more seamless.

Standardized life forms will present the industry with one of the links they need to successfully integrate new technologies while remaining committed to conventional, profitable business practices.

The key to a successful line of standard insurance forms is versatility. The flexibility of a standardized data model allows users to select the technology desired as well as adapt it to the product being offered. That is the answer to many of the distribution quagmires presented by today's high technology.

The ability to collect information of paper or computer and transmit that information via SML or HTML is only part of the solution. Companies need to look for more long-term adaptability. That long-term adaptability is the standardization of not only how the information is collected and transmitted, but also of the information itself.

Standardizing data collection allows systems to share standard information across software applications and forms. When a new form is needed, it is created primarily from the existing building blocks presently available.

If additional elements are necessary, then new blocks are created, and those new blocks are available for reuse elsewhere. These building blocks, incidentally, are also used to electronically transmit the information so that every time a new form is created, most of the electronic application is already completed.

The result of this information library, also known as a data model, is the ability to collect and transmit information both traditionally and electronically. Paper and electronic integration becomes seamless. Electronic distribution portals can be exploited while companies maintain their commitment to traditional ways of doing business. In short, such a system provides the missing link between the past and the present while maintaining a carrier's commitment to the future.

So if money does in fact talk, life insurance carriers need to realize that, in addition to providing this missing link that allows simultaneous exploitation of the new and the old, standardized life forms present carriers with the potential for substantial conventional savings.

ACORD already has the support of industry organizations such as the Medical Information Bureau, the National Association of Independent Life Brokerage Agencies, and the Life Office Management Association, as well as a number of major carriers, agents, and brokers, in this effort.

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NAIC Receives Morbidity Table for Credit Disability

by Robert J. Butler

The Society of Actuaries formed a task force in September to provide a recommendation to the NAIC on the appropriate standard to use in the valuation of Credit Disability insurance. The task force made its recommendation on November 30, 2000, to the National Association of Insurance Commissioners' Accident and Health Working Group (A&HWG) of the Life and Health Actuarial Task Force. The A&HWG will now decide how to implement the recommendation through revision to the Health Insurance Reserves Model Regulation and Statements of Statutory Accounting Principles. Following this review, the group will consider adopting the changes at their next meeting in March 2001.

The Society of Actuaries' "Task Force to Recommend Morbidity Standards for Valuation of Credit Disability" built upon the work of the paper "A Credit Disability Morbidity Table" (published in the special supplement to the Summer 2000 issue of *NewsDirect*). It also relied upon techniques developed by a previous SOA task force that recommended changes to the claim reserve standard for Individual Disability Income.

Specific issues addressed by the task force included how to reconcile divergent experience of 30-day elimination period plans to that of 7-day and 14-day plans. Another issue that needed reconciliation was the interpretation of SSAP Issue paper 59 that seemed to obviate the need for a morbidity standard. Robert Butler and Steven Ostlund, representing the task force, discussed both issues in the presentation to the NAIC.

A copy of the task force report can be obtained by contacting the editor. The executive summary of the task force report is reproduced below.

Policy reserves for single premium Credit Disability Insurance are currently based upon gross unearned premiums. The Task Force has developed a recommendation to adjust the 85CIDA for use as a morbidity standard for these reserves. The Task Force built its analysis based upon the paper "A Credit Disability Morbidity Table," and the statistical methods used by the Individual Subcommittee of the SOA's Task Force to Recommend Morbidity Standards for the Valuation of Group and Individual Disability.

We recommend that the 85CIDA be used as a morbidity reserve standard with incidence rates increased 12%. The resulting policy reserves will be approximately 72% of current unearned premium reserves, but will have a margin of approximately 44% over aggregate experience reserves. To avoid discontinuity between plans using different elimination periods, we recommend that the 14-day elimination period tables be used for both 14-day and 30-day plans.

The study used data provided by 17 contributing companies on single premium policies issued in 1997 to develop an exposure base. These companies wrote in excess of 70% of all Credit Disability premium in 1997. Premium and claim experience was drawn from the NAIC's Credit Insurance Experience Exhibit for these 17 companies as well as for four non-contributing companies. Based upon each company's unique distribution of insureds by age and term of insurance, we could develop an expected claim cost for each plan of insurance written by that company using the 85CIDA. We were able to develop a single actual claim cost for each company by using its distribution of insurance by term and its distribution of premium by state. We first developed a single rate by weighting the prima facie premium rates in each state by the premium volume of that company in that state. By multiplying the single rate by the prima facie loss ratio, we obtained a claim cost.

This claim cost was compared to the expected claim cost developed from the 85CIDA to develop actual to expected ratios. A statistical analysis of these ratios showed that the chosen adjustment factor would develop reserves greater than the experience morbidity reserves 85% of the companies would establish. Beyond looking at the number of companies covered by this standard, we also determined that 94% of the premium volume for the contributing companies would be covered.

The Task Force did not study the effect of interest or mortality discounting in this report. Based upon the relatively short duration of credit insurance contracts, interest discounting would not have a significant effect. We recommend that interest discounting be allowed in a new standard. The benefit paid upon death is refund of premium, therefore, we recommend that no mortality discount be incorporated.

The Task Force did not have termination from claim experience readily available; thus, we do not make a recommendation to change claim reserve standards.

Appendix 2 in the report discusses the difference between a morbidity reserve standard, and an unearned premium reserve standard and why the former should be allowed. This appendix also analyzes amounts recoverable upon refund and the actual lapse experience of the Credit Insurance Industry. Reference is made to the requirement to evaluate reserves relative to the refund liability and to establish excess amounts if needed.

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New Valuation Standards for Credit Insurance Companies

by Steven L. Ostlund

It is difficult to find the valuation requirements for credit insurance products in many state regulations or laws. Many are only found in obscure bulletins or private rulings made to individual companies. The Standard Valuation Model Law provides only general guidance, not specific guidance. Soon this will likely change, due to the efforts of a group of Credit Insurance actuaries, the NAIC, the SOA, and the AAA.

The Actuarial Committee of the CCIA began a study of an appropriate morbidity standard for Credit Disability active life reserves in 1997 to replace the current standard of gross unearned premium reserves. By March of 2000, a paper had been written, and the NAIC had requested the assistance of the Society of Actuaries in determining how to proceed. The SOA established the "Task Force to Recommend Morbidity Standards for Valuation of Credit Disability."

The NAIC re-ceived their report at their December meeting, but also received a request to interpret SSAP 59. SSAP-59 is a credit life reserving principle which had been interpreted as requiring a gross unearned premium reserve be held rather than a mortality reserve. If this interpretation stood, then a morbidity reserve for credit disability would have been unnecessary.

At the NAIC meeting in March, the industry interpretation of SSAP 59 was affirmed, language incorporating the recommended morbidity standard for credit disability was drafted, and exposed for comment. It is anticipated that the new standard will be recommended by the Life and Health Actuarial Task Force of the NAIC to their sponsoring committees, and after further exposure and review, will be adopted in 2002 to be effective for year-end 2002.

Thus after identifying a need for a new valuation standard in the spring of 1997, five years will be required before the standard is in place. What are the benefits to credit insurance companies? Reserves will be reduced about 28%, or about $750 million. This will help relieve surplus strain. Rates of return on the product will be improved, due to the lower reserves, higher surplus, and improved risk-based capital treatment. The morbidity reserve standard will allow better evaluation of the underlying insurance risk than a simple unearned premium standard. In states with low premium rates, reserves may be higher, but they will be directly comparable to other states. With a scientific valuation basis, problems associated with a non-representative insured population (higher ages for example) will be evident to the valuation actuary before it is too late to resolve them. Smaller companies will have an industry standard with which to work, rather than relying on their own limited data.

Copies of the paper, "A Credit Disability Morbidity Table," and the Task Force report can be found on the Society of Actuaries Web site on the Non-Traditional Marketing Section Web page.

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Input at the Next LHATF Meeting

by James R. Thompson

We have been emphasizing the need to get your comments on various NAIC matters in on time. The Life and Health Actuarial Task Force (LHATF) of the NAIC will circulate material that is submitted on time. For the upcoming LHATF meeting for the June NAIC meeting, the following are the deadlines:

May 11: Deadline for submission of materials relative to matters for which decisions will be made or substantive actions taken.

Please note that the revisions to the AOMR will come up in June. Thus, this deadline applies to you! But if you miss this, you can at least try for one of the other deadlines.

May 18: Deadline for submission of materials to be included in the May 2001 mailing of the LHATF

May 25: Deadline for submission of materials that the submitters want distributed at the LHATF and A&HWG (Accident and Health Working Group) meetings in New Orleans (Summer NAIC meeting).

Submission in electronic form to *mpeavy@naic.org* is a requirement for being attached to the minutes.

You can always show up at an NAIC meeting, but inclusion of organized comments submitted in a timely fashion helps immensely. They can be referred to by the people who do show up.

The Status of Proposed New Actuarial Opinion and Memorandum Regulation

by James R. Thompson

Introduction

When an actuary renders an opinion on the reserves of an annual statement, sometimes he also develops an actuarial memorandum describing an asset adequacy analysis. This is governed by the AOMR (Actuarial Opinion and Memorandum Regulation). Based on the company size in net admitted assets and on various ratios (annuity reserves to net admitted assets, capital and surplus to the sum of cash and invested assets and noninvestment grade bonds to capital and surplus), smaller companies may have to perform this analysis and develop a memorandum.

The current AOMR requires annual analyses for companies over $500 million in assets and triennial analyses for companies over $100 million in size. Others can be completely exempt by staying within the ratios.

This has been a bulwark of the regulatory environment for the past decade. At the March meeting of the National Association of Insurance Commissioners (NAIC), the Life and Health Actuarial Task Force (LHATF) accepted two minor revisions to the revised model and forwarded it to the (A) Committee, which considers life insurance issues. That committee will hold the model until the June meeting when it is likely to pass. If so, it will go to the Executive Committee and then the Plenary for final adoption.

In the December issue of *small talk,* I wrote an article discussing the history.

This explained how the regulators got to the point of significant revisions. To encourage smaller company actuaries to consider the significance of this, our Section posted a summary of concerns as well as the revised model on our Web site.

History:

To refresh people's memories, some of the previous history is summarized. Over the years, regulators have been concerned that, with innovative products and newer asset types, some companies could be participating in risky behavior and not have to do any analysis. The current regulation has specific rules for exemption and only addresses the amount of annuities — not UL or other products like equity-indexed life. From time to time, efforts have been made to refine this.

Last year at the March meeting, the regulators decided to develop a revised AOMR. At the September (third quarter) meeting, they put an official proposal on the table for exposure.

Outline of changes:

One major change is the elimination of the exemptions based on size and the ratio tests. Under *Purpose,* it mentions giving the requirements for a statement of actuarial opinion and memorandum. Formerly, it referred to guidelines and standards. Under *Scope,* it allows the appointed actuary to use professional judgment in performing the asset analysis and developing the opinion and memorandum consistent with relevant ASOPs (Actuarial Standards of Practice). "However, the commissioner shall have the authority to specify specific methods of actuarial analysis and actuarial assumptions when, in his or her judgment, these specifications are necessary for an acceptable opinion...." A memorandum shall be required each year

Under *Definitions,* that for Asset Adequacy analysis removes the specific mention of various forms it may take. Thus, this is more general. In the *Opinion,* the reliance language has been modified to state that the actuary has reconciled the underlying basic asset and liability records to annual statement. At the discretion of the commissioner, language in the opinion referring to the adequacy of reserves in light of the assets may be omitted for single-state companies. Thus, a commissioner can exempt domestics which do not sell in other states.

What Happened at Nashville:

Just before the Spring meeting in Nashville, there was some correspondence after the December meeting, and two changes were incorporated into the final draft. In the marked-up version, Section F (1) was changed to read:

"As an alternative to the requirement of 6B(b)(c), the Commissioner may make one or more of the following additional approaches available to the opinion actuary." Section F deals with the Alternate Option. This deals with alternates to the standard language of the opinion which states that the opinion meets the requirements of the state of domicile and are at least as great as the minimum aggregate amounts required by the state of filing. The prior language stated that the commissioner may adopt one of the list of alternates.

The change above, suggested by the ACLI, allows more options. The second change was also to Section F(1). This also deals with alternate language. The previous version required the Company to file a request by March 31. The change allows a later filing.

How This Revised AORMR Affects Whom:

Note that every company (and fraternal society) must provide a memorandum annually. But what tests are required in the memorandum are left to professional discretion (subject to the actuarial standards of practice). This may save work. Let us say that a company uses cash flow testing for all or some of its business. Over a year, if conditions remain the same, it might be up to professional discretion to demonstrate that conditions are the same and refer to the previous year's study. This would probably save time and money overall.

Another problem is that the commissioner can impose his own requirements on the appointed actuary. One might tacitly assume that such requirements will be developed in a reasonable manner and will deal with innovative assets and liabilities. The open-ended language will allow the regulators to keep abreast of changing conditions. But it also allows the regulator to impose detailed conditions on smaller companies selling traditional products with traditional assets. Some fear this discretion.

If the proposal passes, every company will have to do some sort of analysis at least once. This would probably take the form of a gross premium valuation. Remember that ASOPs would be developed requiring this. ASOPs are not subject to state approval. Thus, the Academy will be able to set the details, and the states (with input from the companies) will have not ability to limit this. This lack of limitation is what some fear.

In the course of the development, in order to placate the concerns of the smaller companies, the one-state exemption was included. This means that a company operating in a single state might obtain the consent of the commissioner to omit the memorandum. There are many one-state companies. This includes some fraternals as well as some companies in the burial business. But it also includes some substantial farm bureau companies and large fraternals in single states.

Should single-state operations be the criterion for exemption? There are some companies in only a handful of states who would not be exempt.

This is expected to pass in June. Then it goes to each state to adopt (or not).

A copy of the most recent version can be obtained from the NAIC or the Society's Web site under the Smaller Insurance Company Section.