SOCIETY OF ACTUARIES

Reinsurance News

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newsletter for members of the reinsurance section

LIFE REINSURANCE ADMINISTRATION: PANEL DISCUSSION

There has been a lot of attention given to improving the state of life reinsurance administration over the past few years, with more companies paying attention to the quality and timeliness of the data they pass to and receive from their reinsurers. The SOA Reinsurance Section Communications and Publications team, Bob Diefenbacher and Richard Jennings, recently organized a Panel Discussion involving some key players in the field of Life Reinsurance Administration to discuss the current state of events:

Randall (Randy) M. Benton, FLMI, ALHC,
Senior Vice President, Munich American
Marshall Saunders, Assistant Vice President,
AXA Equitable Life Insurance Company
Chris Murumets, FLMI, AIRC, ARA,
Chief Executive Officer, LOGICQ^3
John Carroll, CLU, FLMI, ARA,
President, TAI Re Life Reinsurance Systems Inc.

Richard Jennings: Welcome to our discussion. To get things started, if you could just quickly introduce yourself and the role you play in your organization.

Randy Benton: I am a senior vice president in charge of our Corporate Operations Division at the Munich American Reassurance Company here in Atlanta. The Operations Division encompasses the administration, claims, IT and facilities functions. I have been with the company for about 24 years now.

Chris Murumets: I am with a newly formed company called LOGICQ^3 here in Toronto in the role of chief executive. We concentrate on consulting, contracting and outsourcing on the operations side for the reinsurance community.

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NEWSLETTER OF THE REINSURANCE SECTION

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SOCIETY OF ACTUARIES

2005-2006 REINSURANCE SECTION COUNCIL PHOTO

ReDIRECTION

by Larry Carson

At my first employer (a small company called The Equitable—you may have heard of it), one of my last projects before I moved on to greener pastures was to negotiate our very first first-dollar quota-share reinsurance agreement, covering virtually all of our new business production. A young whippersnapper of a pre-FSA at the time, I was quite proud of the job I had done. After we signed the treaties, my manager (the incomparable Bill Briggs) called me in. "By the way," he said, "how are you intending for us to administer these deals?" Uh-oh.

Thus was I introduced to one of the harsh realities of reinsurance—a reinsurance transaction is only as good as the administrators, lawyers, accountants, underwriters, and, yes, the actuaries, that make it. It's not enough for us to assume that "someone else is looking out" for those issues. Rather, we, as reinsurance professionals, need to be keenly aware of everything going on that could possibly affect our agreements.

In this issue, you'll see a number of articles that aren't "actuarial" *per se*, but that are of the utmost importance to the practicing reinsurance actuary. We have, among other articles, a panel discussion on reinsurance administration and an article focused on treaty issues, in addition to timely articles on life settlements, mortality bonds, trends in HMO reinsurance and a preview of the reinsurance sessions at the upcoming spring meetings.

Meanwhile, your Reinsurance Section Council has been hard at work charting some new directions for our section. One of the important tasks that we spent time on at our last face-to-face meeting was agreeing on an updated mission statement for our section. It is:

The Reinsurance Section promotes research and education involving reinsurance issues, while creating opportunities to broaden exposure within the reinsurance community.

THE REINSURANCE SECTION PROMOTES RESEARCH AND EDUCATION INVOLVING REINSURANCE ISSUES, WHILE CREATING OPPORTUNITIES TO BROADEN EXPOSURE WITHIN THE REINSURANCE COMMUNITY.

As always, we welcome volunteers, suggestions and (constructive) criticism as we strive to complete the above mission. We have an ambitious agenda, and we very much want you to be a part of it. Please don't hesitate to contact me, or any other council member, if you're willing to help out. ✹

Sincerely,
Larry Carson, Chair
Reinsurance Section Council

Larry Carson, FSA, MAAA is vice president and actuary with the Financial Markets division at RGA Reinsurance Company in Chesterfied, Mo. He can be reached at *lcarson@rgare.com*.

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Marshall Saunders: I am an assistant vice president in charge of reinsurance administration at AXA Equitable in New York. Reinsurance administration encompasses premiums, claims, and systems support. I have been with AXA Equitable 19 years, working in the Controllers division prior to joining the reinsurance department. I am a CPA.

"I THINK IN MANY RESPECTS AS INDIVIDUAL COMPANIES WE HAVE MADE A LOT OF HEADWAY INTO MANAGING THE DATA BUT AS AN INDUSTRY WE HAVEN'T REALLY BEEN ABLE TO ACCOMPLISH A GREAT DEAL IN TERMS OF STANDARDIZATION." —RANDY BENTON

John Carroll: I am President of TAI Inc. a major provider of life insurance software to insurance companies. I have been involved in reinsurance administration for almost 30 years, and working with ceding company issued for the past 20 years. We introduced electronic reporting of billing transactions and inforce information in 1987, almost 20 years ago, and we have expanded our EDI capabilities to include reserves, claims and policy movement.

RJ: Essentially what we want to do here is to present an overview of where life reinsurance administration is these days, and what are some of the main challenges in this area that you face from your particular perspective? Again, what we wanted to get is a flavor of how the perspective varies between the direct side, the reinsurer, and the retro.

RB: So much of what we do today is about the data that we get. Because of the explosion in the amount of business that we reinsure and the amount that we retrocede; as we have moved to first-dollar quota-share reinsurance; as companies as companies acquire and merge with other companies, managing the data and bringing it all together is critical for all of us; for understanding our results and being able to manage the business going forward.

I think in many respects as individual companies we have made a lot of headway in managing the data, but as an industry we haven't really been able to accomplish a great deal in terms of standardization. I am not sure that we will be able to do that in the near future either. One of the critical issues for us, at my company, is being able to work closely with our clients to improve the quality of the data that we receive from them. Quite often, we find that as we work with the data, as we use it to verify treaty parameters and treaty terms and things of that nature to verify claims, and just a whole host of different things that we do with the data, quite often we find that as we dig into the data we sometimes become more knowledgeable than our clients, or counterparts. It has been difficult for us, I think in many respects, to try to get to the right people at the ceding company, at the direct level who can help us understand the data that they send us, and help us improve that data. That is one of the major issues that we are facing.

Bob Diefenbacher: Do you find that is getting any easier now than it was say three or four years ago with clients? Is there now greater emphasis and awareness in the importance of this than there was?

RB: I think there is better awareness and greater emphasis. That is probably the result of a number of things. Sarbanes-Oxley is one driver to encourage clients to provide better data. The other issue that comes about, particularly as companies merge, is that it is not uncommon for an acquiring company to learn about, or to discover large blocks of business or certain types of transactions, that have been overlooked in the whole reinsurance administration process. As they work

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DEAR MS RE:

by Mr. Re

I was just recently involved in a very extended treaty negotiation with my reinsurance pool members. They seemed to be bringing up issues that I feel are somewhat perplexing and currently difficult to deal with administratively. Although I can see where they might have issues with things like time limits on the submission of Errors and Omissions, and concentration of risk; so where is this new emphasis on administrative purity coming from? A couple of my pool members cited SOX compliance as one motivator and others said the push is coming from the retrocessionnaires. What's the real story here and what should I do to deal with this 'Brave New World?'

Signed Mr. Re

Dear Mr. Re:

I remember when the reinsurance world was a simpler, friendlier place—a world without XXX, AXXX and SOX; a place where the rates provided sufficient margin so that reinsurance mortality studies appeared to be an academic exercise; where reinsurance relationships lasted 40 years and the market had a long-term perspective. Where a reinsurer did not need to be 'Brave' and where the 'New World' was not viewed with a great deal of uncertainty.

For some the old world is nothing but a fond memory. In today's world several harsh realities now exist. Reinsurers are required to sign off on the accuracy of their financials. Attempts to retrocede or securitize XXX and AXXX liabilities require the reinsurer's numbers be something more than dime-store fiction. Some people just can't take a joke.

This new paradigm puts pressure on all the former "partners" to a reinsurance treaty. The level of the bar has been raised to such a level that no one in the food chain can afford to be asleep at the switch. Furthermore, the 'Brave New World' we live in involves agreements that are tightly priced and regularly requited. This requires that reinsurers obtain accurate data to generate competitive rate structures and receive current risk information to continue to secure their capacity on all fronts.

I suspect that if the writer would like to provide its pool members with an offer for a long-term agreement, wherein they pay rates with sufficient margin to justify the necessary patience, their reinsurers might be willing to exhibit a modicum of "valor." This could then allow for a continuation of approximate reports which are not trued up for several years and the payment of claims for which no one has seen premiums until claim settlement time.

Ms. Re has often suggested that the administration people be made part of the process before an agreement is signed. Knowing that you are going to get what you thought you negotiated would very likely considerably reduce the angst.

As always, Ms. Re welcomes other viewpoints.

Editor's Note: Ms. Re would like to extend thanks to Mel Young and Craig Baldwin for their invaluable assistance in formulating a response to Mr. Re's thoughtful question.

If you have other viewpoints on the question you would like to submit, or if you would like to write a 'Letter To The Editor,' please send your letters to "Editor—Reinsurance News" c/o Society of Actuaries, 475 N. Martingale Road, Suite 600, Schaumburg, IL 60173 or e-mail: Richard_Jennings@manulife.com.

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with their reinsurers to resolve those problems, to correct those issues, and to get all of that business reported to us, they become keenly aware of the fact the reinsurers are not contractually obligated to accept that business. It is not subject to the E&O provisions. As companies have gone through these types of exercises, they find, in most cases that their reinsurers are happy to work with them, but they are not obligated to accept the business. That has placed a lot of emphasis on the need to improve the reporting as well.

JC: There are still a lot of companies out there that have not kept pace with the systems, procedures, going along the treaty lines, or even having the staff that is adequately trained to handle the large volume of reinsurance that is created by quota share and first-dollar arrangements.

Reinsurance itself is activity-laden, and the information really needs to be accurate and timely, reflecting what occurs on a company's policy administration system. As Randy pointed out, as companies buy other companies or blocks of business, this can create a huge administrative burden both for the acquiring company and for the reinsurers that are on the blocks of business.

I think Sarbanes-Oxley has heightened the awareness among senior management at most companies, and I think they are looking at the issues surrounding reinsurance administration. Some of these companies have actually dedicated resources to dealing with some of the shortcomings, but I think there are still companies out there that have been concentrating on documenting their current procedures, but have not yet committed to implementing long-term solutions.

CM: For example, on the Sarbanes-Oxley issue, quite often you see SOX-dedicated resources, yet if we are doing an independent assessment of a company, for example, they can be SOX compliant but there may still be significant operational risks. So a lot of people like to think that being SOX compliant gets rid of all your issues, but that is really not the case at all.

On the merger and acquisitions side, every organization seems to have something going on and there can be significant overpayments and underpayments going on. There was recently a very public example. A ceding company overpaid almost $100 million due to an administrative error. From what we have seen the issues are exactly what everybody has already said—the lack of attention to operations, the lack of funding and the lack of real strategy around some of the administration issues out there. From what we have seen, there are more examples out there like the recent public one. Others have happened that are even bigger than that, and you know there are going to be more because the attention isn't quite there yet.

Treaty language is, without a doubt, getting to be a lot tighter now than it ever has. There has been more time spent with lawyers and in arbitration conversations in the last six months than I ever had in the prior ten years. So treaty language is getting a lot more specific, and I think that is forcing people to be a little bit more proactive in their offer letters.

RB: I think we are moving from having treaties between partners to having contracts between partners. It is definitely becoming a legal process rather than the old tried and true gentlemen's agreement type situation that we had for so many years in the reinsurance industry.

CM: Do you think that is better or worse Randy?

RB: I think it is necessary. I think it is unavoidable. I think it definitely complicates things in many respects.

CM: You want a lot more consistency in language. And you want people to be able to enforce contracts for many years. You had all this

language and nobody would enforce it anyways. It has to be legal, but it doesn't have to be as complicated in my mind because we are seeing treaties getting signed a little bit faster; however now if you go through internal legal areas, there are more parties involved. Not only your own reinsurance company, but it involves corporate and it may require input from other offices. So from what we have seen of lags, it seems to be going up and that doesn't really help anybody.

RB: Those lags in getting the treaty signed have, direct implications on reinsurance administration. As a reinsurer, if we don't have a signed treaty, we often see premium and claims come into us before the treaty is signed. It is difficult to understand or to know how to determine whether that business is being administrated appropriately, and that claims are being submitted appropriately, if we don't have a signed treaty. Our counterparts at the direct companies are at an extreme disadvantage too. How do you go into a reinsurance administration system and build the treaty parameters, and establish the rules and the criteria for administering the business, if you don't have a signed agreement in front of you?

JC: In fact in our own system we had to put in logic so that if a company came out with a new plan or a new reinsurer where they did not have an agreement in place, the system would create placeholders for that business and later would retry to add reinsurance when the treaty tables were available. We have clients that have placed thousands of cessions long after they began selling the product.

CM: We had one situation before where there was a block of business that was so far out, without ever getting agreement to terms, that we tried to send it back. I don't see how you could ever avoid this. As soon as you have accepted that business or as soon as you have cashed that check, it could be argued that you are on the hook. How can you ever stop getting a check cashed at the very front end? So from a legal implication, not getting these arrangements stuff signed quickly upfront creates a ton of problems downstream.

RB: In the absence of having the signed treaty, it is definitely prudent to have a signed Letter of Intent in place. That doesn't cover all of the different types of situations that you need to address in the treaty in order to properly administer the business, but it is certainly a good indicator of what the intentions were between the parties involved.

CM: Plus you need that Letter of Intent signed to get the reserve credit, correct?

RB: Yes.

JC: I think with a Letter of Intent you are supposed to have a treaty done within 90 days, right?

"REINSURANCE ITSELF IS ACTIVITY-LADEN AND THE INFORMATION REALLY NEEDS TO BE ACCURATE AND TIMELY, REFLECTING WHAT OCCURS ON A COMPANY'S POLICY ADMINISTRATION SYSTEM." —JOHN CARROLL

CM: Is a Letter of Intent enough to get the reserve credit or are people pushing that you have to have the contract?

RB: Actually the requirements to have the documentation signed within 90 days is something that I think ceding companies, the direct industry, may be aware of but it is a very important thing. The implication is certainly more serious for the direct market than it is for the reinsurance market. It comes down to them being able to take credit for the reserves on the business that they have ceded to us. If they don't have that agreement in place within the prescribed amount of time, then technically they cannot take the reserve credit. It is not a real issue for the reinsurance industry or for the retrocessionaires

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but it is something that the direct writers should be very aware of.

CM: Does that come up in your conversation with direct writers Randy?

RB: Yes it does.

BD: So, Randy, is it fair to say that your letters of offer are now getting more detailed as well? I mean certainly that is true with us as a retrocessionaire.

RB: Yes, I think the Letters of Intent have to be more detailed than they have been in the past.

BD: I have always thought of the treaty as essentially the specifications for the admin area, and I am not sure that all direct writers have that kind of concept. If you think about it that way, you sure wouldn't leave specifications for a systems project until two years after you implement the project.

JC: That is a good analogy.

RB: Going back to some of the difficulties in administration we were talking about before we got into the treaty issue, there are a couple of things that we are seeing that really impact the quality of the data and the type of reporting that we are seeing. One of the things that we see quite often is that there are inadequate internal control systems in place in terms of reinsurance administration, and that there is poor integration of systems, with the reinsurance administration system not being appropriately integrated with the underwriting system for example.

I think there is too much of a reliance on vendors like TAI to make sure that reinsurance admin systems have been put in place appropriately and that they satisfy all the internal control requirements that they should. I think sometimes when companies hire TAI or another vendor to come in and do the work with them you certainly need to be able to depend on their expertise and their knowledge and their experience from all the years of work in that area. Ultimately it is still the direct company's responsibility to make sure the system has been implemented correctly, and that the internal controls are what they should be, and have been properly integrated with their other systems.

CM: Randy, do you see a weakening of good operational experience or good operational capabilities at the direct companies?

RB: I see that, yes. It is definitely an issue. I jokingly tell some of my fellow senior managers here that I can go out and hire ten good actuaries much faster than I can find one good operational person to fill a spot here at MARC. Reinsurance administrators, people who have the right kind of experience to do the kind of job that we need them to do, are hard to come by.

JC: A lot of the good people that I have met over the years are either retiring or they are merging and acquiring another business. You just don't see that strength a whole lot anymore, and you don't see a lot coming up through the ranks.

MS: I certainly agree with what Randy just said. There is no question it is difficult to replace good administrative people.

JC: One of the things that Marshall had the advantage was in acquiring another company, is that his company, was able to keep existing staff on board during the acquisition so they had a sense of what was in place, and how it was to be administered. That is not always the case in an acquisition. Sometimes files arrives in boxes and it is up to the acquiring company to figure out and interpret what was the intent of the original ceding company.

RB: Sometimes in transactions like that, John, we underestimate the value of what I call the institutional knowledge.

MS: There is no question we were helped by having staff who knew their business for their operation.

BD: We have talked a lot about the need to report on a timely basis, but what is the definition of timely out there at this point? How long does it take to get from a policy being issued to getting reported out to the reinsurer? What would the reinsurer consider timely at this point? What would a direct writer think is timely? Three months? Or is six months more realistic?

MS: Well, I haven't been at all the meetings, but I think we have been one of the companies pushing for shorter times on the retro side, in terms of late reporting and trying to nudge the industry into shorter reporting cycles.

BD: As a retro, if we were talking about months I think we would all be high-fiving each other.

MS: Yes, I think we were pushing for six months at one time. I don't know that is viable but that was our long-term goal, our vision on the horizon. From a direct point of view the only thing that would hold me up from reporting, is really having a valid in-force policy on the admin system. If there is a long underwriting lead-time, the policy may be in underwriting for four, five or six months and we won't get it.

RB: Reporting from the direct company to us as a reinsurer is typically like this: if a report is due at the end of January, it is not uncommon for us to actually receive that report about mid-March, or about a 45-day lag in reporting to us. If you had a policy issued in January that should have been on the January report, right there you have a 45-day lag. With us, it is not uncommon to see policies reported in the four to five or six-month lag range from the direct companies.

CM: That is six months after issue Randy?

RB: After issue, right.

CM: Really?

RB: Yes, that is not uncommon. We have to have time to translate the data, to analyze it and process it ourselves. Then we have to have it flow through our admin systems all the way through to the retrocession systems and then report it. Typically we have a 30- to 45-day lag in reporting to the retrocessionaires. So by the time that process is completed you may be looking at nine months total lag by the time it gets to the retrocessionaires. I wouldn't be surprised in seeing those types of lags at all.

MS: Well, nine months wouldn't be too bad Randy. As you know, some of the problems are cropping up because we are getting policies two, three, and four years later.

BD: That is actually the point I wanted to make too. I think nine months might be the mean for how it is reported, but there is an awfully long tail to that.

MS: Yes, nine months is probably something we could live with.

CM: I remember last year I think it was Gary Wilson did a study. I think he was looking at from issue to when the policies were showing up on his inforce file, was something like 18 to 24 months.

BD: That is an awfully long time. Do you have that kind of tail from direct writers?

MS: Not so much on the direct side.

RB: I don't think most of our clients are reporting in the 18 to 24 months range. It is sooner than that, although we do have exceptional cases where that is certainly true.

CM: Yes, there are probably a few chronic troubled clients.

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JC: All companies that use our system should be able to report transactions monthly. Some companies may choose to accumulate the monthly reports and send information quarterly. Hopefully most of them are sending it out within 15 days after the end of the month or quarter. Even those companies where we have gone in and converted them from spreadsheets were typically reporting their data at least quarterly.

"I THINK THE REINSURANCE INDUSTRY, AND THE RETROCESSIONAIRES TOO, HAVE PROBABLY BEEN TOO SLOW TO ADDRESS THE POOR REPORTING. SO IT IS JUST NOT THE ISSUE WHERE THE DIRECT MARKET USES IT AS A CRUTCH. I DON'T THINK WE HAVE DONE AN ADEQUATE JOB SOMETIMES IN ADDRESSING THOSE ISSUES AS QUICKLY AS WE SHOULD HAVE." –RANDY BENTON

One of the issues that comes up here on the retro side, is that a lot of the reinsurers have issues with matching up lives on their systems because of the various formats that come in. Even breaking up the name can be an issue, so I think sometimes it takes quite a bit of analysis. As you know, Randy, we have worked with a few of you on the retro side and matching up those lives can be somewhat of a challenge depending on the amount of data that you get from the ceding company.

Some of this is caused by being able to consolidate and figure out what really needs to be retrocessioned out on a life, and sometimes if the information is not reported accurately or correctly, it is only seen after the fact when a reinsurer may be vastly over-retained on a particular life.

RB: I think that is true, John. In our case, when we do risk accumulation, we are looking at well over 20 million records. To give you an example of some of the data issues, one that we just recently discovered with one of our large clients was a situation where they seemed to randomly take the middle initial and place it in the field with the first name. There was no pattern to this, so there was nothing that we could do to go through and scrub that data, or to apply any kind of systematic correction to it. When it is a random thing that we cannot correct, we have to go back to the client and work with them to try to get them to identify the source of the problem and correct it. If you throw in that extra letter here and there in that first name or in the last name, more importantly, it plays havoc with your risk accumulation.

RJ: Do you see a lot of problems with second-to-die products? I have heard second lives being coded as spouse or some sort of amendment to the first life record, but not really a true second-to-die or second life format?

RB: I think you see all kinds of issues with second-to-die, and with just the data in general. Almost every client's data is unique. Even clients who use TAI, or some other system, don't always use the data files consistently. If you are dealing with a company that uses an old version of TAI versus one of the new versions of TAI, mapping the data, translating it, and understanding those issues with each client's data can be very difficult sometimes.

BD: That has implications beyond risk accumulation. It makes it incredibly hard for reinsurers to do a mortality study or things like that.

RB: Absolutely.

CM: That is what people tend to forget. It truly is the beginning of everything, whether you are looking at mortality studies, retention checking, calculating reserves, experience refunds or financial statements, yet it doesn't seem to get the same awareness inside

some organizations where that is where you should be spending some time interviewing resources.

MS: Where this may ultimately be going is there may be some push in the industry. I think that there maybe already has been some push from a business standpoint of being a retro. Whatever the agreed upon time is for timely reporting cases that don't meet that deadline, they may be considered on a fac-ob basis, and some of the companies may look to disavow the risk if they don't have the capacity two or three years down the road, because it plays havoc with your retention calculations.

CM: One of the general things I have seen as well is there are genuine errors that happen that should qualify as E&O. As Randy mentioned earlier, going from a treaty to a contract, almost true errors are getting contractually written out of a contract. So everybody is supersensitive to making any kind of mistake. It is altering how people are doing business and where people are doing business.

RB: That is something I have been very concerned about, because we don't need to develop treaty language that eliminates coverage of a true E&O type situation. The types of problems we are talking about—the chronic late reporting, the systemic and repetitive errors in administration—they have never been subject to E&O provisions in my opinion. But we do need to be careful that we do not exclude coverage of true E&O, the one-off type situations.

BD: That is certainly not what E&O was originally intended for yet many cedents have assumed that it was, right?

MS: Well, I think there is a difference, between chronic late reporting and an E&O. I would agree with you.

CM: The super sensitivity is justified now in the sense that E&O provisions have been used as a crutch for bad administration; however, you do worry that the industry is going almost too far and almost not allowing that true error which does happen. We need to be conscious of only punishing the behavior that is meant to be punished, as opposed to punishing everybody.

RB: I agree with you, but I don't look at it just as the direct market using E&O as a crutch for poor reporting. I think the reinsurance industry, and the retrocessionaires too, have probably been too slow to address the poor reporting. So it is just not the issue where the direct market uses it as a crutch. I don't think we have done an adequate job sometimes in addressing those issues as quickly as we should have.

"I HAD ONE SITUATION BEFORE WHERE THERE WAS A BLOCK OF BUSINESS THAT WAS SO FAR OUT WITHOUT EVER GETTING AGREEMENT TO TERMS THAT WE TRIED TO SEND IT BACK. I DON'T SEE HOW YOU COULD EVER AVOID THIS ..." —CHRIS MURUMETS

BD: Said another way, we asked earlier about the emphasis of direct writers on administration and that may be increasing. We see, even within our own organization, the emphasis on administration increasing. I have seen it at other companies that I have worked at, and I think it is going on here, where now there is an awareness of the importance of our own administration that was not occurring some years ago.

RB: I agree with that.

MS: I also agree.

RJ: We talked earlier about the inconsistency in the way ceding companies report data. I would like to turn the conversation to the implementation of standards. Is this the cure-all? Or is this something that companies are

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working towards? Perhaps Chris could comment as to what he is seeing from a standards adoption viewpoint, and the others can respond as to whether that is something they are working towards, or are they fine with the way things are?

CM: The standards certainly aren't one fix for everything. They are far from being a silver bullet. Where we are with standards is, as most of you know, that we are working with ACORD. ACORD is the global insurance standards body that is very heavily involved in the P&C market, and has very recently become very active on the life insurance side. So they own, develop and support standards across all lines of insurance.

What ACORD and the reinsurance community are trying to come up with is an inforce file that can be used, and that everybody agrees, is a good minimum dataset to manage retention. That first round agreement has happened and an ACORD XML and flat file will be coming out of one large direct company this quarter. The Reinsurance Administration Professionals Association (RAPA) committee is also working with the same direct company on a standard transaction file. Again, it is meant to not only standardize what fields are used, but it also goes to one of Randy's comments earlier about the consistent understanding of what those fields are. It is trying to come up with a common dataset, as well as a common understanding of what is actually in that field to solve that specific purpose.

In terms of adoption, anybody who has been going to RAPA meetings for the last decade knows that adoption is always the hard part. There have been standards before this, and there have been conversations about this for easily ten or more years that I have been participating in. What we are hoping with the initiative this time is truly just trying to push on the implementation side, so it's still very small steps.

It is not a silver bullet by any means in our mind. It is a starting point. Randy mentioned earlier that standards will never be adopted in this industry, but I truly hope it does just from the sense that we have to make the moving of data mechanical, so that all the other stuff that we should do—analyze, understand, interpret the data, so that we can actually spend the effort, energy and resources there as opposed to just importing and translating.

In terms of other files the ACORD initiative is looking at, I believe that after this there is an audit file. A merchant bank in New York that wants to work with ACORD to do a securitization standard has also approached us. It is a long ways off but that is a sign of where things are going.

RB: How do these standards differ from the work that was done by some of the ACORD working groups in the past?

CM: Remember the LREACT message?

RB: Yes, that is specifically what I am talking about.

CM: LREACT was part of the basis for this, but trimmed down to capture data that you truly need as an inforce file? So we honed it down a little bit, because I am sure you remember the implementation guide for LREACT was about 100 pages. It was very intimidating. So

they took that, pared it down to what was truly necessary to manage retention, which was what an inforce file was for, and then they standardized the meaning of the fields using ACORD language, but otherwise LRE-ACT was the basis of it all.

RB: A couple of thoughts I have about the standards process. I think we all agree that if we had a standard format that would be wonderful. But that doesn't address the quality of the data necessarily. If you don't address internal control systems; if you don't address the proper integration of the reinsurance admin systems or the policy admin systems, and the underwriting systems at the direct companies; if you put poor data into a standard format, that really doesn't do much for us. So there is still a big issue with making sure that we get good data out of the direct company systems and then put it into a standard format.

The issue has always been the economic models that have been developed really did not make sense. We haven't been able to show the direct market why or how standards will benefit them. It clearly benefits the reinsurers; it clearly benefits the retrocessionaires; but convincing the direct client to spend money to move the reporting over to these standard formats has been difficult for us to do. We haven't been able to present a model to them that clearly demonstrates why moving in this direction would be truly beneficial to them as direct writers.

RJ: Maybe it should be in the pricing.

RB: Maybe we need to be talking about that to our retrocessionaires.

BD: I think actually that is part of the issue. There has historically anyway been such competition in the life reinsurance marketplace, that reinsurers have been loathe to want to push these things for fear that clients would just go somewhere else to someone who was emphasizing standards less than they were.

CM: Randy, I wouldn't disagree one iota that data quality is by far the biggest issue. What I hope to see happen is at least standardizing some of the transport of it, but on the other side would be the other value that ACORD brings to this, specifically, is that a lot of these organizations, which are largely direct writers, are spending a fair bit of time, energy, and money on implementing standards in other places in their organizations which truly does add value like underwriting on the brokering commission side.

"I DON'T THINK AS AN INDUSTRY WE HAVE BEEN ALL THAT GOOD AT ENFORCING STRICT REPORTING REQUIREMENTS. COMPANIES HAVE BEEN WILLING TO ACCEPT LESS THAN QUALITY DATA. I THINK THAT IS CHANGING..." –JOHN CARROLL

So when you are talking to them in that forum, this is just another reason to use a standard. So it is not a big expense any more but because they are generally on-side because they are seeing value from other parts of their organization with standards, that hopefully that they will extend that existing work to look at their outbound reinsurance.

RB: That's great, and that is really the point I am making, is we have to be able to demonstrate the value to the direct market for doing this. Historically, we have not been able to do that.

JC: I don't think as an industry we have been all that good at enforcing strict reporting requirements. Companies have been willing to accept less than quality data. I think that is changing because I actually have been contacted by a couple of ceding companies that probably wouldn't have considered purchasing a software program like mine, except for the fact that they have been denied reinsurance.

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RB: I think part of establishing new reinsurance relationships is that we are doing a lot more due diligence up front with potential partners. It used to be that we mainly looked at underwriting. But today, I think we are also looking at claims administration, practices, experience and expertise, and we are also looking at administrative capabilities, including their admin systems and their ability to provide quality data.

JC: Randy, I also think that even if we were to get adoption of the ACORD standards by the major companies, I still think we would not get compliance among some of the smaller players, and that is still going to cause a significant administrative issue for any reinsurer or retrocessionaire.

RB: Absolutely.

BD: I want to go back to the lag issue again, because this is a hot button for me. So let us say the average time to get all the way through the cycle is nine months, and the time to get to the reinsurers is three months, or something like that. Is there any way with today's technological framework to shorten that? One analogy I have heard used is that I can use my bankcard anywhere in the world and it deducts the money from my checking account almost instantly, so why can't we do the same thing in insurance? That is probably an oversimplification but is there a way to shorten the cycle any?

RB: Not really. I think that the issue that you bring up is that whenever you look at the banking industry, or other financial institutions like mutual funds and stock trading, all those things happen instantaneously, and here we generate billions of dollars in transactions and yet the life reporting seems to be so much more significant in reinsurance.

CM: I think it goes back to Randy's earlier point about getting good operational people. The technology has always been there as in other financial sectors, but it is a business implementation issue, and getting the right business people to focus on the issue doesn't seem to be happening.

RB: It is the fact too, that historically we haven't had the support from senior management to make reinsurance administration and reporting a top priority. I think that is changing and is moving in the right direction, but I think we still have a long ways to go in that regard.

I think, for too many years, reinsurance was looked at as a cost center. It was something that was a cost to companies until the company realized they had poor administration and hadn't reinsured a large case, and they had a claim. That is how it became important to them. I think today the emphasis is different. I think there is a different expectation, a different desire on the direct side to provide good and timely data, but it requires a commitment from the top in terms of IT resources, and human resources, and just across the board in order to achieve that and make it a realization.

JC: One of the issues you raised, Chris, just a minute ago was securitization, and if securitization is going to become prevalent in the industry, the bankers and the investors are not going to be satisfied with the quality of administration that is out there today.

CM: Good observation.

BD: So we have talked a lot about issues, and we have talked a little about the question over the adoption of standards, but I will just throw it out there again. What other recommendations would we have for moving forward? Are there other things in the industry that we can do? It sounds to me, if I summarize what I have heard today, is the patient is improving but we all wish it were improving more and faster than it is today.

JC: I think organizations like the SOA Reinsurance Section have to continue to put reinsurance administration issues in front of the members. I think companies like mine have to continue to use technology to improve reporting capabilities, and then educate our clients on how to best use those tools. I think insurance companies have to take responsibility for their reinsurance administration, and commit to doing it accurately if they want to self-report the reinsurance business and not later decide to restate the business due to administrative shortcomings Finally, I think reinsurers and retrocessionaires have to insist on timely and accurate reporting from their trading partners.

CM: I wouldn't disagree with any of that and as we talked about it a couple of times, it is putting emphasis on administration that is required. There has to be some time, energy and effort put into training and getting good people and paying for good quality operations.

RB: I agree with all of that. I think the one thing I would add too is something I touched on a little bit earlier. I think all of us in this chain, the retrocessionaires, the reinsurers, the direct companies, we all need to do a better job at making sure that all of our needs are better aligned than they have been in the past.

MS: Yes, I agree with everything that has been said. I think we are making some strides and some headway. All these relationships have been changing and everybody has commented on this. Sometimes there has been a little head butting, and sometimes companies get together and sometimes they don't, but we are all working towards better relationships and improved systems.

There is no question it takes senior management's dedication to get the right kind of systems in place, and that is what we had to at my company, but you have to have somebody's attention at the top so that you can get the right system in place if you are going to administer your reinsurance.

BD: We enjoyed these frank discussions and want to thank you very much for your time. ✺

LIFE SETTLEMENTS—2006 TRENDS, DEVELOPMENTS AND EMERGING ISSUES

by Michael L. Frank

What is a life settlement? It is the sale of an unwanted life insurance policy and is done since it provides a greater cash settlement than lapsing or surrendering a policy. Upon selling a policy (completing a life settlement transaction), the covered insured will typically be the same as before but the policy owner and the beneficiaries will be a different party, typically the company buying the policy (i.e., life settlement company). The life settlement company takes over premium payment and receives a death benefit.

These transactions exist since a life settlement company can individually price a policy, and depending on the characteristics of the risk, exceed the nonforfeiture (cash) values of a policy. Substandard or impaired risks could see higher purchase prices as a percentage of face amounts. The impact of individual medical underwriting (if an individual has a deterioration in health since policy issue date) can potentially offset the added expense provided by the life settlement company. These expenses include overhead, licensing/bonding fees, financing facility costs and life settlement brokerage commissions.

This document will focus on recent trends including the insurance company debate, consumer advocacy, premium financing and the changing environment for the secondary insurance market with focus on the life settlement industry.

Insurance Company Debate

Among life insurance companies, there is an ongoing debate about life settlements. Insurance companies traditionally do not want their sales force to be involved in life settlements. Their agents are either not permitted or the practice is frowned upon (agents may not have coverage under their insurance company's professional liability). However, some insurance companies, including reinsurers, have had an interest in life settlements for the perceived returns and have participated in the life settlement industry as a funder (financial backer).

Other discussions cover whether or not life settlements will have an adverse financial impact in the life insurance industry. As of today, a very small percentage of life policies have been sold as life settlements, so the impact today is probably minimal. However, as the life settlement market grows, one concern is that life insurance policies are lapse-supported, so a life settlements (remember a policy does not lapse from a life settlement but stays inforce) will have an adverse impact to insurance companies since policies will more likely payout a death benefit. Conversely, many life insurance policies (*e.g.*, increasing term) have increasing premium rates and mortality charges with the insured's age so policies remaining inforce will receive more premium to cover increasing mortality.

Empirical Data

It will be interesting to see how this debate will change over time as the industry obtains empirical data in the future. Empirical data will be difficult to measure since there are many moving parts and changes in key areas in life settlements, for example:

- Changing practices in medical underwriting (this is a key factor in setting the price on a transaction) since market perception was that life expectancy calculations were artificially low (aggressive) and now have become artificially high (conservative).
- Changes in risk management such as varying facilities costs, financing and stop loss protection (*e.g.*, Lloyds type reinsurance policies of

expected life expectancy plus two years are no longer available).
- Changes in the economics of the transaction (life settlement brokers are now receiving less fees as a percentage of the entire transaction with policyowners receiving a bigger piece of the transaction).
- Changes in origination and sourcing of policies (e.g., increasing number of premium financing companies).
- Size of the existing market is debatable and ever changing.
- Changing insurance company practices with rating older ages and changes in table shaving practices.
- Changes in practices of the seller as the consumer becomes more educated, as they learn the potential for financial arbitrage and the importance of selecting reputable buyers (flight to quality).

Furthermore, A.M. Best's release of Life Settlement Securitization guidelines will increase the interest of life settlements as an investment vehicle and may create changes in how portfolios are accumulated, priced and managed. More analysis will be needed with actuaries and financial analysts becoming more involved in the pricing and growth in venture capital and hedge funds in this market. For details on A.M. Best's release in September 2005, see Web site link *http://www.ambest.com/debt/lifesettlement.pdf*.

The market could also see significant turnover in portfolios in the future if venture capital and hedge funds are unable to accumulate a critical mass in policies and achieve the rates of returns desired when they entered the business.

Consumer Advocacy

Regulators have developed various requirements and compliance to protect consumers purchasing life and health insurance products. For example, there are requirements pertaining to: (1) advertising including words used and print size; (2) handbooks explaining insurance; (3) regulations to protect brokers from churning or replacing policies (e.g., NY Regulation 60) for additional fees; (4) licensing requirements for insurance companies and agents; and (5) other—we could go on forever with this.

Very little guidance or requirements exist for individuals that sell their policies. This is a work in progress and not consistent by state. One critical area not addressed is disclosure for the transaction. For example, does the seller of the policy (policyowner) know what fees are associated with the transaction (e.g., brokerage commissions)? This issue was debated at the November 2005 SOA annual meeting, and probably will be debated in future SOA meetings.

One might argue that a life settlement transaction might be viewed similar to a security, so entities facilitating the transaction should have a securities/broker dealer license (NASD oversite) plus be required to fully disclose all fees to protect the consumer from expense gauging.

THE MARKET COULD ALSO SEE SIGNIFICANT TURNOVER IN PORTFOLIOS IN THE FUTURE IF VENTURE CAPITAL AND HEDGE FUNDS ARE UNABLE TO ACCUMULATE A CRITICAL MASS IN POLICIES AND ACHIEVE THE RATES OF RETURNS DESIRED WHEN THEY ENTERED THE BUSINESS.

However, mandating disclosure is a challenging item and could potentially backfire on the insurance industry. Consumer expectation might be to get more disclosure of insurance company fees (beyond surrender charges) in the original purchasing of an insurance policy. For example, insurance companies will need to disclosure insurance brokerage commissions, profit margins, overhead, etc., which are typically not disclosed to the consumer. Most policyowners do not know the commission rate that their agents receive.

Also, will the consumer care what costs the life settlement company has to pay to manage their business as long as they get their price? Likely, the consumer will want to know what their broker gets for a life settlement transaction and may even want to know what their broker gets for life insurance policies at issue.

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Another concern is whether or not the consumer understands the pros/cons of doing a transaction. The insurance departments require insurance companies and brokers to provide basic information to consumers about a life insurance policy. Clearly the consumer would benefit if this was required as part of a life settlement transaction. Life settlement companies advertise the pros of doing a life settlement (your insurance policy becomes liquid—you get cash for selling your policy beyond the nonforfeiture values that an insurance company would pay for your policies).

HOWEVER, AS THE LIFE SETTLEMENT MARKET GROWS, ONE CONCERN IS THAT LIFE INSURANCE POLICIES ARE LAPSE-SUPPORTED SO DOING A LIFE SETTLEMENT WILL HAVE AN ADVERSE IMPACT TO INSURANCE COMPANIES SINCE POLICIES WILL MORE LIKELY PAYOUT A DEATH BENEFIT.

From the consumers' perspective, policyowners could potentially be made aware of the following:

- When you sell your policy, the buyer of the policy may not keep it for the life of the policy and could sell it to another organization. A consumer may think that institutional money is buying their policy, but the buyer may not ultimately be keeping it. This is a key non-financial aspect of the transaction that a consumer should be aware of, and may influence the seller on whether to deal with quality organizations or "fly-by-night" companies.
- The seller of the policy may have potential tax implications so discuss with your accountant or financial planner.
- Someone else gets paid a benefit if the insured (or potential original policyholder if the same person) is deceased. Some people may not be comfortable with this issue, but this is the fundamental premise of a life settlement and viatical transaction.
- A life settlement company makes more money if the insured dies sooner (*i.e.*, the benefit is paid earlier and the premium and financing fees are paid on the policy) and the company loses if the insured lives longer. Interestingly, a similar argument could be made about annuity policyholders that insurance companies make more money if they die sooner, and lose if they live longer.
- It would be of interest to know whether the life settlement buyer has board of directors or owners with criminal records or litigious issues with their local insurance department.
- Does the seller have the same estate planning needs or another solution for estate planning? Are there any beneficiaries (e.g., family members) that would need financial protection when the insured dies?
- Even if beneficiaries are revocable, do you want their blessing before doing the transaction? This may potentially deter some life settlement transactions from being done. This could be a potential requirement for beneficiaries who are immediate family. It might provide additional protection to a life settlement company as well since the liability of family members complaining later that he or she were eligible for a benefit is mitigated.

Licensing

Licensing requirements for life settlements vary by insurance department jurisdiction (state specific). A significant number of states do not have any licensing requirements. Others may require solely an insurance broker/agent license. As a result, lawyers, accountants, financial planners, etc., are able to handle these transactions. Certain states require a Viatical license, which could be deemed different from a life settlement license (viaticals are typically associated with terminally ill patients with less than 24 months to live; life settlements are typically for seniors ages 65 and above). Insurance departments are focusing more attention in this area, so expect a more consistent licensing requirement over time for life settlement licenses including clarifications between life settlements and viaticals. It will be interesting to see if certain jurisdictions require a securities license for certain types of transactions.

Definition of Insurable Interest & Premium Finance Companies

Insurable interest for the beneficiary and policyowner is established at the original purchase of an insurance policy. It has been debated whether insurable interest exists on policies purchased through premium finance companies. If an individual buys a policy through a premium-financing company, and elects not to repay the loan, then the premium-financing company may be the potential owner of the policy. This creates a potential life settlement even before a policy goes outside the incontestability period (two to three years) when the insured decides not to repay the loan.

Premium finance companies are spending significant dollars on legal fees to ensure or at minimum mitigate the risks that could be associated with insurable interest. As an example, New York insurance law section 3205(a) defines insurable interest as:

(a) in the case of persons closely related by blood or by law, a substantial interest engendered by love and affection.
(b) in the case of other persons, a lawful and substantial economic interest in the continued life, health, or bodily safety of the person insured, as distinguished from an interest which would arise only by, or would be in enhanced in value by, the death, disablement or injury of the insured.

This regulation may create potential hurdles for premium finance companies focused on life insurance.

However, the insurance industry reaction pertaining to premium finance companies is mixed. These companies are clearly a source of premium production for insurance companies and create the opportunity for additional policies to be purchased.

Some premium finance companies have become more sophisticated and are looking at trying to arbitrage policies (create life settlement transactions) for policies receiving a better rating (pricing table) at policy issuance than expected. Some insurance companies will not write life insurance policies financed by premium finance companies.

Insurance companies are assessing other approaches in identifying policies at issuance that could be potential life settlements by requesting completion of questionnaires at policy issue asking whether the insured (policyowner) will potentially either use the policy as a collateral assignment or potentially sell it in the future. These questionnaires could be attached to the issued policy with the insurance company's intent to make this part of the contract. It will be interesting to see the insurance industry reaction if insurance companies attempt to enforce these questionnaires such as:

- Denying coverage for unfavorable answers to questionnaires;
- Restricting transfer of policies to premium finance companies for policies that insureds (policyowners) that do not want to pay back premium loans; and
- Enforcing incontestability clauses if policies are transferred or sold within the incontestability period (or potentially beyond it).

It will be interesting to follow the secondary insurance market including life settlement transactions and premium financing corporations over the next few years. ✹

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MORTALITY CATASTROPHE BONDS AS A RISK MITIGATION TOOL

by Ronnie Klein

Securitization is defined as: *The process of aggregating similar instruments, such as loans or mortgages, into a negotiable security.* Although relatively new to the life insurance industry, securitizations are certainly the most talked about topic by far. For most people unfamiliar with securitizations, they are usually all lumped into one bucket. However, there are many different types of securitizations serving different purposes.

In general, there are three types of securitizations that have been completed in the life insurance arena. The first type releases embedded value from a grouping of policies. The main purposes of this type of deal is to release capital to reinvest into core businesses, to prove to regulators and ratings agencies that the present value of future profit from a block of business is a liquid asset and to increase the return on equity for the underlying business. Swiss Re completed an embedded value securitization in early 2005 named Queensgate. Although Queensgate was the first securitization of its kind, one should expect more of these embedded-value type securitizations in the near future.

The second type of securitization, and one that is gaining much popularity amongst life insurers, is one that transfers large statutory reserves to the capital markets. These reserves, mandated by the regulation known in the industry as Regulation XXX, are believed by most experts to be highly redundant. By using the underlying business as collateral, the company issues securities to the capital markets. The investor trades principal for a better than a market return. The ceding company then gets to use the principal invested to set up the large statutory reserve thereby receiving a large tax deduction. This type of securitization also relieves the ceding company of the anxiety present in other types of Regulation XXX solutions. The investor's principal is returned as the profits on the underlying business emerge. Companies that have successfully completed this type of securitization include Genworth, Scottish Re, Banner Life and Prudential. Please note that while generally these four transactions fall into the same bucket, these deals are constructed quite differently.

The final type of securitization is one more commonly found in the non-life insurance arena. The purpose of this type of transaction is to transfer extreme risk into the capital markets as a risk mitigation tool. Catastrophe bonds such as earthquake bonds and windstorm bonds have been available in the market for years. The life insurance industry completed its first Mortality Catastrophe Bond in late 2003 under the name of Vita Capital, Ltd. Swiss Re completed this deal and decided to offer a similar bond in 2005 dubbed Vita II. It is this type of bond that will be the focus of this article.

There are many ways in which a company can mitigate extreme mortality risk. The simplest method is to self-insure this risk. A company may chose to set aside a portion of profit each year until it builds a meaningful contingency reserve with which to offset an extreme mortality event. The benefits to this approach are that it is the most cost efficient method, there is flexibility in how much to save each year, and when the reserve can be deployed, and it matches up perfectly with the losses. The problems of this approach are the length of time it takes to build a meaningful reserve, that the reserve will most likely be a drag to return on equity, and that future management will have access to this reserve.

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Another approach is to purchase a simple high-limit stop-loss cover. This tool also has the benefit of matching actual losses with reimbursements. In addition, it is very simple to negotiate a deal and to administer. The drawbacks to this tool are it is relatively expensive, it usually has exclusions (such as terrorism, nuclear, biological) and the ceding company is exposed to the credit risk of the reinsurance company. The last of these drawbacks is extremely disconcerting in that losses large enough to trigger this cover will probably damage the reinsurer enough to make payment suspect.

The final method is a Mortality Catastrophe Bond. This tool is much more complicated than the prior two. It involves external investors who may not be insurance savvy. Therefore rating agencies must be engaged. In addition, external parties must review each component of the bond so that the investors are comfortable with any calculations. Also, don't forget the lawyers. These deals usually involve offshore companies set up as special purpose vehicles (companies set up with the sole purpose of issuing this bond) and lawyers must be involved to set up these SPVs. Finally, one must pay the investment bankers to underwrite these bonds. This sums up one of the major drawbacks of a mortality bond—cost. In fact, the fixed and variable expenses are so large that a minimum bond issue of $250–$300 million is usually deemed as the minimum worthwhile and cost efficient enough to issue a bond.

Here is how the bond works. Investors "buy" bonds and receive a return on their investment. If an "event" does not occur, investors receive their principal back at the end of the term (three to five years). If the event does occur, the investors will lose part or all of their investment, which is paid to the insurance company to offset some or all of its loss. The bond issuer must set the underlying mortality used, the trigger point for an event, the grading from a partial payment to a total loss of investment and the rate of return paid to investors.

An underlying mortality index is set as the base mortality or expected mortality. Although this mortality could theoretically be the company's own expected mortality, the capital markets will have a difficult time understanding and trusting these numbers. That is why a standardized table is most often used. This is called a parametric bond. The parameter here could be population mortality weighted by country, age and gender to generally replicate the underlying insured-life business.

MORTALITY CATASTROPHE BONDS ARE AN EFFECTIVE METHOD TO MITIGATE MORTALITY RISK TO A LIFE INSURANCE ORGANIZATION.

Once the base mortality is set, the bond issuer must determine a trigger point. The trigger point is usually set at 100 percent + X of expected mortality. The larger X is, the lower the chance of an event and, therefore, the investor can expect a lower return. At some point 100 percent + Y, there is a total loss to the investor. Between 100 percent + X and 100 percent + Y, there will be a grading of loss to the investor (See Figure 1 on page 22). Depending upon the rating of the bond and the current market climate, the return is set by the bond issuer. Just to complicate things a bit, a bond issuer may issue different levels of risk to reach investors with different risk appetites. The capital markets people call these tranches, because they need to have a language that regular people don't understand. Tranches closer to the expected mortality will generate higher returns and tranches further from the expected mortality will generate lower returns.

The benefits of this type of approach to risk mitigation are that there is absolutely no credit risk, the bond issuer may be able to release some risk capital and all events are covered. The drawbacks are cost, complication and the risk that insured-life mortality will be poor even though the population mortality index used will not generate an event. This is called basis risk for some odd reason that no capital markets person can explain. It is simply a mismatch risk and can work in either direction. So, for example, if there was an epidemic that effected lower income people aged 35 to 65, the population might have an event that would trigger a loss to investors but the bond issuing company might not have a serious mortality event. In this case, the

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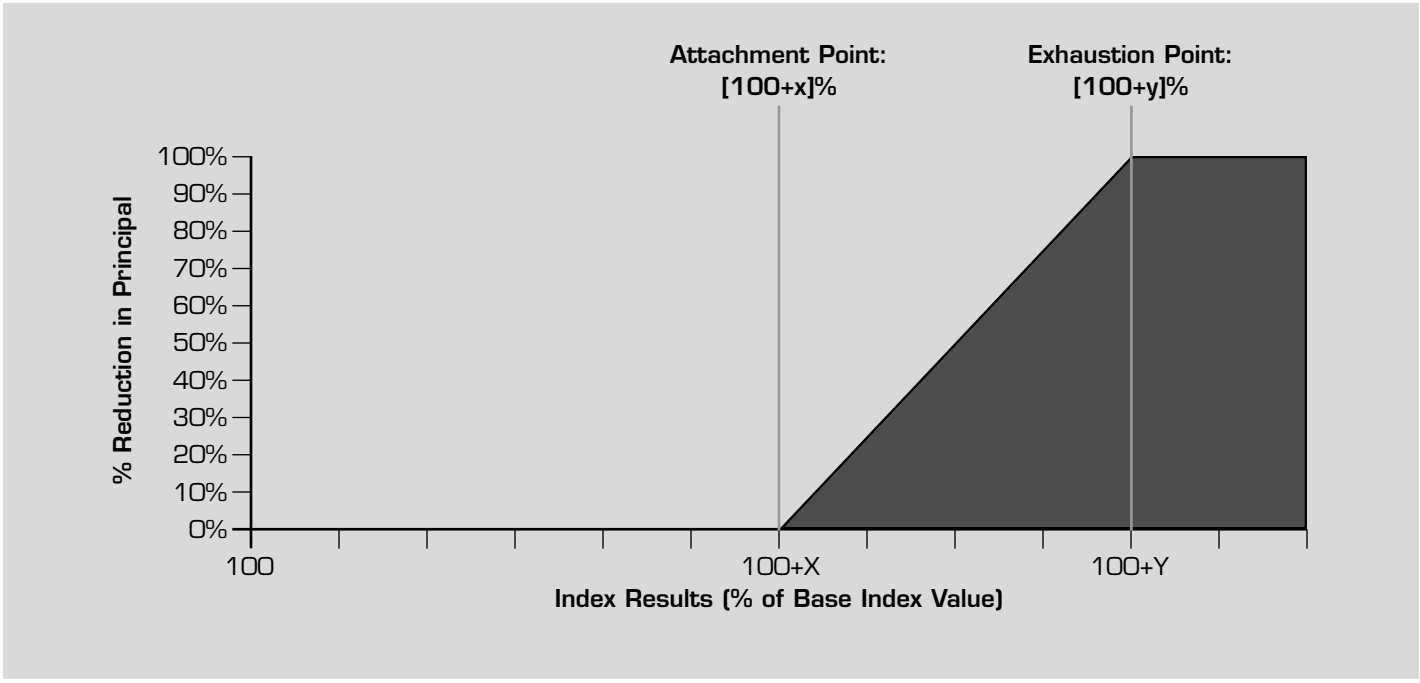
Mortality Catastrophe Bonds ... from page 21

insurance company would get an unnecessary benefit. Basis risk must be well understood internally and well managed.

Mortality catastrophe bonds are an effective method to mitigate mortality risk to a life insurance organization. So are self-insurance and high-limit stop loss covers. The best approach to risk mitigation is probably some combination of all three methods. While working on any type of a securitization is interesting and completing one is exciting, a company must be certain of its goals before moving down this path. For companies exposed to large amounts of mortality risk, willing to accept basis risk and fearful of additional credit risk, a mortality catastrophe bond could be a very viable solution. ✹

Figure 1: Mortality Risk Transfer—Payout



MANAGED CARE UPDATE

by Mark Troutman

[Portions of this article were reprinted with permission from *Contingencies* magazine]

Introduction—This article provides an update on HMO market trends and reinsurance products and services supporting them.

A. HMO Market Trends

Several market forces have been affecting HMOs:

1. **Costs**—Average health care costs moderated in 2004. According to a Mercer Resource Consulting LLC study, the average cost of U.S. employer-sponsored health coverage rose 7.5 percent, to $6700 per employee. This is the lowest rate of increase since 1999. However, continued expensive advancements in medical technology, pharmaceuticals and the aging of the population continue to increase medical costs at a rate more than the change in the consumer price index.

2. **Product Design**—HMOs have offered more open networks and less management of care given the consumer backlash in the early part of the new millennium. This same Mercer survey also indicated that employers, in response, are raising employee cost-sharing with higher deductibles, co-payments and coinsurance features. Health Savings Accounts (HSAs) are being increasingly offered as part of a cost control solution. The number of members enrolled in HSAs has doubled to 1 million. The number of insurance companies providing HSAs has tripled to approximately 100. (*Source: America's Health Insurance Plans Survey*).

3. **Profitability**—The profit margin of the HMO sector improved in 2003. Average profit margins for the industry were 3.78 percent of premium versus 2.5 percent for 2002. The increased financial strength of HMOs is demonstrated by the rising stock prices of the big publicly owned chains. The financials are improving for various reasons: increased earnings potential, government expansion of Medicare / Medicaid opportunities and cyclical profitability. Further increases in profitability are being reported for 2004, although the majority of the earnings are concentrated in relatively few companies. (*Source: Weiss Ratings*).

4. **Market Share**—HMO market penetration is declining somewhat. The number of Americans enrolled in HMOs dropped to 69 million in 2004 from a peak of 80 million

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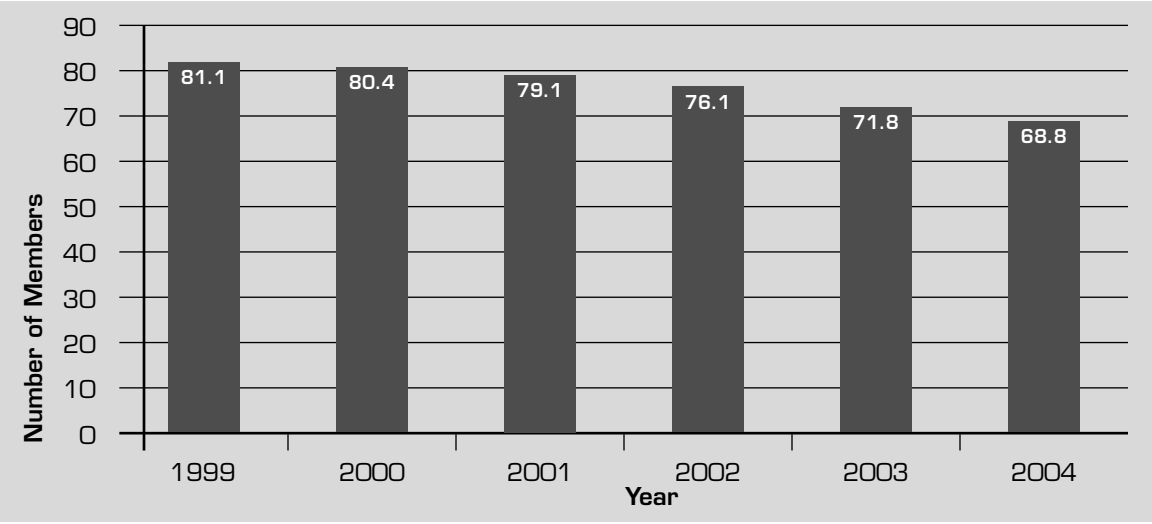
Figure 1: HMO Members (in Millions)



Managed Care Update from page 23

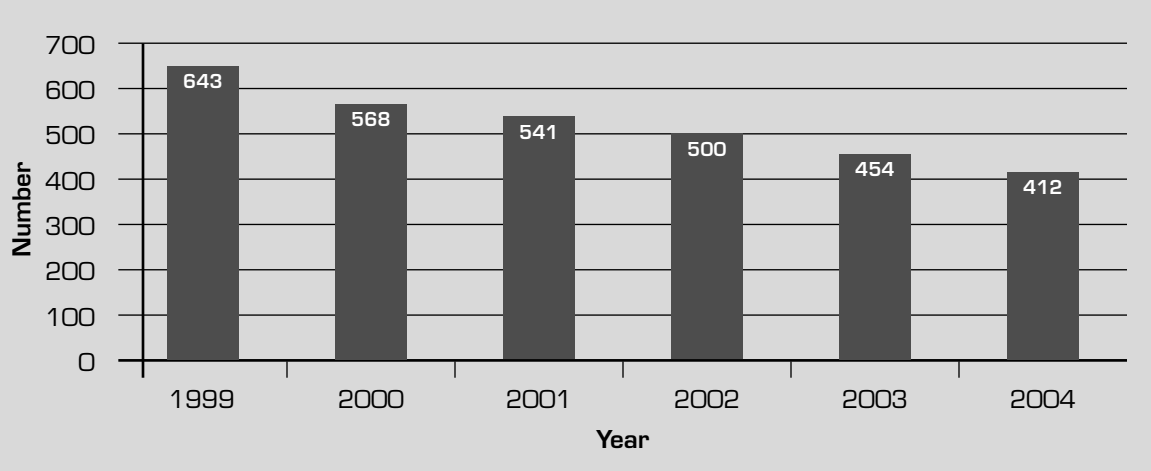
in 2000 (Source: Interstudy Publications). PPOs have picked up the slack as they provide a broader access and greater flexibility than HMOs, but usually at higher cost. PPOs now cover 109 million Americans. Table 1 on page 23 demonstrates the decline in HMOs membership.

5. **Provider Contracting**—More provider contracts are designed to provide pay for performance to efficient providers. Managed care companies increasingly design programs to steer patients to high quality, low cost providers in the environment of "managed care lite." The Centers for Medicare & Medicaid Services (CMS) has begun a new demonstration project to test financial incentives, which reward quality improvements. Providers have gained more contracting strength due to consolidation in the hospital market. This allows them to negotiate higher increases on per diems, percents of billed charges or other managed care contracting arrangements with payers.

6. **Consolidation**—The merger-and-acquisition activity of the major health care chains continues to shrink commercial and Medicaid plan reinsurance opportunities. Publicly held corporations strive for growth to achieve economies of scale, expand their market penetration in various geographic areas and demonstrate revenue and earnings growth to their shareholders. Most of the publicly held corporation health care chains buy little, if any, reinsurance. There have been over 100 HMO acquisitions the last 10 years by major chains such as United Healthcare, Anthem/Wellpoint, Coventry, PacifiCare, Humana, Cigna and Health Net. There has also been a flurry of M&A activity by major Medicaid chains such as Molina and Centene. These two companies alone have engaged in 10 transactions in the last 18 months. Table 2 demonstrates the HMO market consolidation (*Source: Interstudy Publications*).

7. **Government Programs**—At the same time that the traditional reinsurance market is contracting, however, there is some expansion in Medicare and Medicaid HMO reinsurance opportunities as the state and federal governments continue to privatize these programs in a perennial effort to control costs. The 2003 Medicare Modernization Act increased government reimbursement significantly to managed care plans. In 2005, Center for Medicare & Medicaid Services (CMS) received nearly 150 new health plan organization applications to offer services to Medicare Advantage beneficiaries through

Figure 2: Licensed HMOs



new Medicare Advantage HMOs and Medicare PPOs. Over 100 current Medicare Advantage HMOs are also increasing their service areas. (*Source: CMS Medical Affairs*).

The effort to provide high-quality, cost-effective healthcare with broad access to providers continues in this segment.

B. Reinsurance Underwriting and Coverage Trends

The most important trend affecting the traditional HMO reinsurance market is the continued industry consolidation previously described. This causes the HMO excess market to be a small, mature market where reinsurance opportunities are trending downward. This follows from the continued consolidation of HMOs through M&A activity as well as from very small HMOs going out of business. Such plans occasionally cease operations due to a provider hospital owner capital constraint, or a desire to focus on maximizing revenue across payers rather than using an HMO as a distribution channel for their services. Due to the consolidation in the market, reinsurance competitors must "steal" business from each other in order to grow. This places pressure on reinsurer margins and essentially makes it a buyers' (i.e. soft) market. This increased competition in a declining market is offset somewhat by the expansion of government programs described here.

The relative increase or decrease in the entire market depends upon the future consolidation trends and the consistency of government policy regarding privatization of government health care liabilities in Medicare/Medicaid programs.

Another coverage trend among HMOs currently buying reinsurance is a movement towards higher deductibles and higher average daily maximums. This is a natural trend in an inflationary environment. An average daily maximum (ADM) is a per diem inside limitation on reinsurance claim reimbursement. It maintains an aligned economic interest between the reinsurer and the HMO regarding health care claims which exceed the reinsurance deductible. From a pricing perspective, increasing the deductible lowers premium rates while raising the ADM increases premium rates. Doing both in combination often results in relative premium neutrality and higher coverage efficiency as a larger percentage of claims over the chosen deductible are reimbursed instead of being limited by the ADM. In fact, some HMOs are now looking for coverage, which has no such inside limits. Different carriers will offer such coverage with various underwriting guidelines. The reinsurance contract with no ADM limitation is much more expensive than one with a reasonable ADM limitation (sometimes two times more expensive). The exact magnitude of difference depends upon plan experience and provider contracting arrangements.

It's still very important to keep apprised of all of the particulars of a given state Medicaid program. Some states take back certain high cost claim risks in Medicaid populations and others don't. The eligibility requirements of any state-provided reinsurance protection affect the size of the external reinsurance market. Furthermore, underwriters need to be aware of what risks are moving in or out of their exposure base as the government program provisions change.

Some reinsurers are beginning to add additional exclusions and limitations in their agreement to move costs back to the managed care plan. Some are more obvious than others. An example would be limiting organ transplants to two per member or imposing an average daily maximum even to a diagnosis related group (DRG) payment arrangement. It is important for the purchaser to ensure an "apples-to-apples" comparison of benefits for various reinsurance proposals when comparing rates.

General inflation for hospital inpatient reinsurance coverage has been roughly 9–10 percent. Outpatient facility drugs have trended higher at 10–12 percent. All of these trend rates have additional leverage as the deductible increases, but are subject to change in the per diem provider contracts as well as outlier provisions, which revert a per diem or DRG contract to a percent of billed charges.

What items do buyers take into consideration in their purchasing decision? Benefits and rates are far and away the key consideration. Claim service and reinsurer financial strength are a distant second and third. There is little impact in the buying process

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from reinsurer capabilities such as managed care vendors (*e.g.*, transplant networks) or ancillary product solutions (*e.g.*, employer stop loss, group life or out-of-area medical programs).

THE RELATIVE INCREASE OR DECREASE IN THE ENTIRE MARKET DEPENDS UPON THE FUTURE CONSOLIDATION TRENDS IN THE INDUSTRY AS WELL AS THE GROWTH OF MEMBERSHIP IN PRIVATE PLANS ACCEPTING GOVERNMENT HEALTHCARE LIABILITIES IN MEDICARE/MEDICAID.

Another reinsurance trend is the increase in coverage features, which have some form of swing rate, aggregating excess corridor or other alternative premium funding method. Each of these attempt to give some cash flow advantage to the client while trading upside and downside risk with the reinsurer. It's particularly hard to compare these provisions among carriers on many of these product permutations. These features may seem to reduce an insured's reinsurance costs; however, when they need protection, these provisions actually add to their costs and load an additional margin. Caveat emptor.

One knows the market is softening when one sees two-year rate guarantees and products with no ADM being offered more prevalently, particularly by brokers. These were major contributing factors to the last soft HMO reinsurance market of 1998–1999.

Brokers—Brokers still control 20–25 percent of the market, notwithstanding the fact that the Elliott Spitzer investigation has shed a new light on brokering activities. The HMO reinsurance market is still segmented into companies, which acquire business through brokers and those reinsurers who write business directly with the HMO. This could be done through their own employees or by contracting with managing underwriters. More and more plans are willing to solicit direct market bids in addition to the bids they receive from retail brokers. Otherwise, they are limiting their access to several of the major HMO reinsurance markets.

Regulatory—The ongoing broker/reinsurer practices inquiry led by New York Attorney General Elliott Spitzer is primarily focused on certain major property and casualty carriers in national brokerage firms. In addition to focusing on contingent commission arrangements and bid-rigging, some of the more severe forms of financial or finite reinsurance are under close scrutiny. It's unclear whether or not the same kind of scrutiny will be applied to the life and health reinsurance marketplace and the smaller fish in the pond. The investigation is still a work in progress, and most HMO reinsurance brokers who were accepting contingent commission arrangements from reinsurers have ceased doing so.

Brokers, managing underwriters and reinsurers are subject to a wide variety of licensing and compliance requirements. Companies are advised to make sure that their brokers, consultants, reinsurers and reinsurance intermediary managers and reinsurance intermediary brokers have all the required licenses and approvals to conduct business in their state. Some states recognize reciprocity when the entity has a similar regulation and license in their home state. Others require additional filing and licensing requirements in addition to the reciprocity provisions.

Provider Excess—The early part of the new millennium was highlighted by poor profitability on these arrangements where HMO risk had been shifted to capitated providers. Several carriers have exited the market, and there have been no significant new entrants. In general, the number of reinsurers appears to have stabilized, and they are achieving their target profit margins. Most providers, which continue to receive capitation have demonstrated the infrastructure to manage risk and to negotiate the appropriate capitation rate. Many of the past players who took capitation first and asked questions later took a bath. Rates have increased significantly, and liberalizations in terms and conditions have moderated (*i.e.*, a hard market). This is welcome relief to provider excess carriers who had significant losses in that line in prior years.

Carve-outs—There are no significant changes in purchase of neonatal or transplant carve-out products. Plans purchasing such carve-outs often have inadequate medical management capabilities or

provider contracts of their own. They are looking to replace uncertainty with certainty, as with any reinsurance premium, but on a first dollar quota share basis rather than excess of loss. Transplant carve-out market is estimated at $50 million of premium with URN, a subsidiary of United Healthcare, being the largest player due its acquisition of SRI. Distribution is through a wide variety of sources including direct sales, brokers, TPAs, managing underwriters and carriers.

Catastrophic Claims/Managed Care Vendor Trends—There are three main trends in this area:

1. Organ transplants are still limited by the supply of organs. There is still a significant waiting list for organ transplants.
2. There continues a rising rate of multiple births. Increase is due to advances in and greater access to fertility therapies and an older age of childbearing.
3. Many HMOs offer disease management programs themselves or through disease management vendors. Typical programs target asthma, diabetes, cardiovascular disease, chronic obstructive pulmonary diseases and maternity as well as end stage renal disease. Most disease management claims do not reach the catastrophic claim level.

A recent survey by Summit Re of its managed care clients regarding what types of managed care vendors they currently have in place produced the following results:

1. All clients have some form of utilization management, consisting of pre-authorization for admissions and certain other services in concurrent review of inpatient admissions.
2. Disease management programs are primarily internally developed and focus on the diseases most prevalent within the particular health plan. The sophistication of the program is varied as well as the degree of the outcome reporting. A few plans have a specific end stage renal program and more are planning to do so in the future.
3. Almost all clients have contracts with pharmacy benefit managers, which may include reduced pricing for high-cost specialty pharmaceuticals or they have contracts with separate companies for those drugs. The contracts provide discounts off of average wholesale prices of the drugs. Some companies also include supplies and home nursing (when medically indicated) as a part of the contracts.
4. The majority of the clients access some form of network for transplant services such as United Resources Network (URN).
5. About half have some form of out-of-network repricing capabilities. Pricing negotiations are done internally for some health plans or are contracted out to a national PPO /repricing vendor.
6. Approximately 25 percent of the clients have contracted with a neonatal intensive care unit (NICU) management vendors.

Figure 3: Managed Care Programs

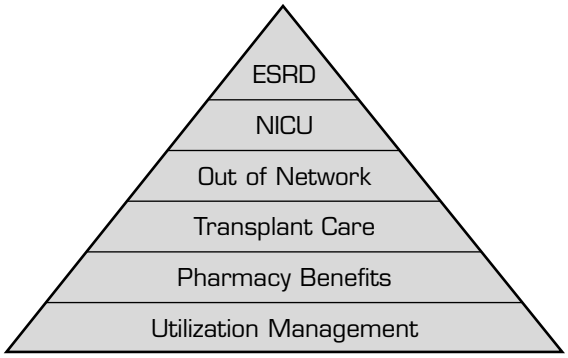

Figure 3 indicates the prevalence of various types of programs offered by managed care plans.

Conclusion—From a reinsurer's perspective, there are positive and negative aspects of the current managed care reinsurance marketplace. It has consolidated and softened somewhat, but still has plenty of opportunity for knowledgeable, disciplined reinsurers. As some trees fall and are cleared away, other trees are planted. The relative increase or decrease in the entire market depends upon the future consolidation trends in the industry as well as the growth of membership in private plans accepting government healthcare liabilities in Medicare/Medicaid .✺

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CONTRACT FINALITY—WHAT A CONCEPT!

by Larry P. Schiffer

*Editor's Note: This article previously appeared on the International Risk Management Institute Web site (*www.irmi.com*) and is reproduced with permission of the publisher, International Risk Management Institute, Inc., Dallas, Texas from IRMI.COM. This article was written from a P&C perspective, the concept applies to the non-P&C world as well.*

The reinsurance industry is unique among business ventures for its history of handshake agreements and contract terms written on the backs of cocktail napkins.

In what other industry do businesses agree to deals without a signed, final contract document, which clearly states all the terms and conditions of the parties' agreement? Where in business do you ever see contracting parties begin to perform under a contract months and, historically, years before the final contract wording is executed? Welcome to reinsurance, where deals worth millions of dollars happen often with no more than minimal terms and conditions actually written down as agreed between the parties.

Historical Practice

In the London market, where reinsurance effectively began, the reinsured's broker visited underwriters individually and provided them with the basic details of the business to be reinsured. If the underwriter was interested, the underwriter would "scratch" or sign the broker's placement slip, which was nothing more than an outline of the basic terms and conditions of the reinsurance with a place for each reinsurance underwriter to indicate the level of participation the underwriter wished to assume (the "line"). The broker would go from underwriter to underwriter until the slip was completed (the full percentage participation sought by the reinsured was agreed to by various underwriters). Sometime later, the lead underwriter and the broker, on behalf of the reinsured, would agree to the final contract wording. In the meantime, premiums are paid, accounts are rendered, and losses are paid all before a final contract is actually signed by the parties. Sometimes the parties agree to end their relationship before the final contract wording is even agreed.

Remarkably, this system has persisted nearly unchanged into modern times. Even in markets outside London, including the United States, the practice of contracting via a slip—exchanged by fax or later by e-mail—instead of a final contract at inception is common practice. One can only suspect that this unique practice arose because of the special relationship between market participants and the reciprocal duty of utmost good faith. Or perhaps the speed by which certain insurance covers were needed, especially for marine or construction risks, required minimal evidence of coverage to be followed up by formal contract wording.

Even more remarkable is the historical lackadaisical attitude toward ever finalizing the contract wording by many in the reinsurance industry. While not common today, it was not so long ago that parties to a reinsurance contract would fail to finalize the contract wording even after years of dealings between each other as reinsured and reinsurer.

The Obvious Problem

It should be obvious to the casual observer of the "agree now and contract later" practice in the reinsurance industry that failing to agree to a complete and certain contract wording before performance begins will likely cause problems if a dispute arises. While the slip provides the basic terms and conditions of the reinsurance contract, the devil is in the

details. What does the phrase "arbitration clause" mean in a slip? What kind of arbitration? What are the qualifications of the arbitrators? How many arbitrators will decide the dispute? Or what does "ultimate net loss" mean without a full definition? Does it include allocated loss adjustment expenses or incurred but not reported losses? We can go on and on with brief headings of agreement and references to so-called standard clauses that beg for full elucidation.

A typical term in reinsurance slips is the phrase "to be agreed." This phrase may be used for many important terms of the contract, including the dispute resolution clause and many of the definitional clauses, not to mention the final wording ("final contract wording to be agreed by lead underwriter"). Of course, these "to be agreed" terms often are the basis for subsequent disputes between the parties.

For years now, parties to reinsurance contracts and their counsel have been fighting over the terms of slips after the parties' relationship has terminated without both parties having signed the final contract wording. What controls the relationship, the slip or the unsigned wording? When the reinsurance relationship breaks down, undefined terms, abbreviations and minimalist language provide fodder for disputes. While the parties may have thought they understood each other when the slip was signed, it often turns out that there was no clear agreement on the detail of the contract now in dispute. The failure to have a final and certain contract before the contract term begins means that the parties really have no idea what they truly agreed to in detail.

Evidence of the seriousness of this problem was highlighted by the failure to have a property insurance contract in place for the World Trade Center. While not a reinsurance problem, the placement of such a unique, layered property cover followed the traditional pattern of having the insurers agree via slips and temporary wordings before the final property insurance contracts were signed. As we all know, while the cover was "in place" on July 1, the terrorist attacks on September 11 occurred before there was universal agreement to the final contract wording. The failure of a certain and uniform definition of "occurrence" cost Mr. Silverstein hundreds of millions of dollars (so far).

IT SHOULD BE OBVIOUS TO THE CASUAL OBSERVER OF THE "AGREE NOW AND CONTRACT LATER" PRACTICE IN THE REINSURANCE INDUSTRY THAT FAILING TO AGREE TO A COMPLETE AND CERTAIN CONTRACT WORDING BEFORE PERFORMANCE BEGINS WILL LIKELY CAUSE PROBLEMS IF A DISPUTE ARISES.

What Is Being Done About Contract Finality?

The problem of entering into an agreement before final contracts are signed has spurred various regulatory responses across the industry. On the financial front, the National Association of Insurance Commissioners adopted a rule requiring that final contract wordings be signed within nine months of the contract's effective date to allow for accounting treatment as prospective, as opposed to retroactive, reinsurance. Even with the nine-month rule, many reinsurance contracts are still not finalized in a timely manner. Moreover, the nine-month rule really only addresses an accounting issue and does not lead to contract finality and certainty at the time the contract goes into effect.

In the London Market, "contract certainty" is the latest buzzword. The London Market has drafted a Contract Certainty Code of Practice, which was created by its Market Reform Group. Under the Code of Practice, contract certainty must become a reality by December 31, 2006. What that means is that reinsurance contracts incepting January 1, 2007, in the London Market must be final and certain on the effective date of the contract.

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Essentially, the idea of contract certainty is that each party will know exactly what the product is that is being sold at the time it is being sold, so it can be priced correctly and so the purchaser knows exactly what he or she is buying without any later misunderstandings. Now, under Contract Certainty, terms "to be agreed" have to be agreed by the inception date of the reinsurance contract.

In the United States, contract finality or certainty has not yet been imposed to the level of the London Market Code of Practice for Contract Certainty. The nine-month rule, which really comes out of Part 23 of SSAP 62, requires that the reinsurance contract be finalized—reduced to written form and signed within nine months after commencement of the policy period—but allows the contract to incept before the contract is finalized. With the problems and lawsuits emanating from the World Trade Center, the call for contract finality at the inception date of contracting is growing louder.

Conclusion

Agreeing to terms and conditions of a business contract on the day of placement of the contract is only a foreign concept in the world of insurance and reinsurance. While contract finality on the date of inception will not eliminate disputes between the parties, it will go a long way toward reducing disputes arising out of "to be agreed" and other ambiguous or barely referenced contract terms. Moreover, just because there is no current regulatory requirement in the United States for a finalized contract at inception does not mean parties may not insist on a finalized wording at placement. Tell your reinsurance broker that you want the final contract wording agreed and signed no later than the effective date of your reinsurance contract. You never know, maybe you will be the first to have a final contract wording in place before the inception date of your contract. ✺

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ON THE PATH OF SECURITIZATION

by William R. Wellnitz

The Setting

Since the early 1990s, regulators and industry representatives have worked at trying to devise a reasonable approach to reserving for life insurance products with limited level premium guarantees or no-lapse guarantees. We have evolved from unitary reserves to Regulation Triple X reserves, through modifications under Actuarial Guideline 38, and now on to the 2005 CEO Compromise amendment to AG38 which sunsets in 2007. Already in the works is a proposed "Interim Solution" to set reserving standards starting in 2007, which would stay in effect until principle-based reserving becomes a reality. However, until principle-based reserves arrive, we will continue to live in a rules-based reserving world where the rules result in statutory reserves well in excess of what anyone today would consider economic reality. The problem then becomes how does one insulate their company from the financial affects of these non-economic reserves so that the company can continue to offer products that are economically attractive.

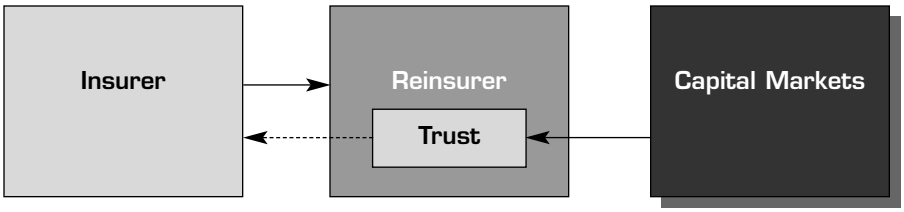
The historic solution sets have tended to rely on conventional reinsurance and, in the case of no-lapse guarantees, perhaps some creative policy design. Neither of these approaches are problem free. From the reinsurance perspective, the historic reliance on letters of credit is raising some issues regarding pricing risk and capacity. And regulators' reaction to policy design ideas, as evidenced in the debate leading up to the 2005 CEO Compromise amendment to AG38, certainly has put a damper on this approach to addressing the high level of reserves on policies with no-lapse guarantees.

New Alternatives

So the industry is looking for new alternatives for dealing with these non-economic sources of capital strain. Banks have been anxious to step into the fray here. A number of banks are offering multi-year letters of credit—something that three years ago would have been unimaginable. Moreover, they are more frequently available not only with current-issue dates but also with future dates to create a synthetic LOC that's even longer term.

Capital market funding of reserve credit trusts is also beginning to attract attention, with contingent funding, direct funding and securitization being seen as popular variations. All of these structures follow a model similar to Figure 1. The insurer originates the risks and cedes it to the reinsurer, the reinsurer establishes a reserve credit trust for the benefit of the insurer, and the capital market provides the funds to be deposited into the trust.

Figure 1: Basic Capital Market Solution Model



Determining the Deal Structure

A key issue here is deal structure. What will the capital market see when it looks at this structure? Whose credit risk are they seeing—the reinsurer's, that of the reinsurer's parent or affiliate, or some other party's credit exposure? From the standpoint of the parties involved, what are the impacts on their financial ratios? How does it affect metrics such as debt/equity leverage or spread-products exposure? Is the deal structured to be on- or off-balance sheet? What is the line of recourse? Bottom line, if something goes bad whose funds will fill the hole?

Figure 2 on page 32 shows a typical securitization structure. A parent owns both the reinsurer and the insurer in the transaction. In addition, there's an issuing vehicle, the capital market and a guarantor.

In this structure the reinsurer issues surplus notes to the issuing vehicle, the issuing vehicle uses those surplus notes to collateralize a debt offering to the capital market, and a guarantor guarantees to the capital market that the debt collateralized by the surplus notes will in fact perform. In this structure the capital market will see the credit rating of the guarantor, but also knows that behind the structure are the surplus notes whose repayment is dependent on the performance of the business within the reinsurer. This model is a classic non-recourse structure.

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Figure 3 involves a rated affiliated holding company serving as the issuing vehicle. As with the earlier structure, surplus notes are issued by the reinsurer but now instead of using a monoline's credit as a guarantee, the capital market looks to the credit strength of the affiliated holding company. This structure is recourse and carries the rating of the holding company.

A little twist on the structure involves a situation where the reinsurer is downstream from a special-purpose holding company and the holding company issues debt to the capital market (See Figure 4 on page 33). This could be done without a guarantor but more typically would involve one since the effort to get the holding company rated may not be wholly worthwhile.

The basic difference is that this model does not involve issuing surplus notes. The special-purpose holding company issues debt and the reinsurer has a capital-dividend relationship with the holding company. Probably the biggest advantage of this structure is the switch to dealing with regulatory rules for dividends and capital, as opposed to those for surplus-note treatment.

Establishing the Reinsurance Company

Other considerations involve how the reinsurer will be organized. The most common approach today is to form a captive reinsurance company. Hawaii, South Carolina, and Vermont are common onshore jurisdictions, while Bermuda, the Cayman Islands, and Ireland are common offshore places for incorporation.

Figure 2: Typical Securitization Model

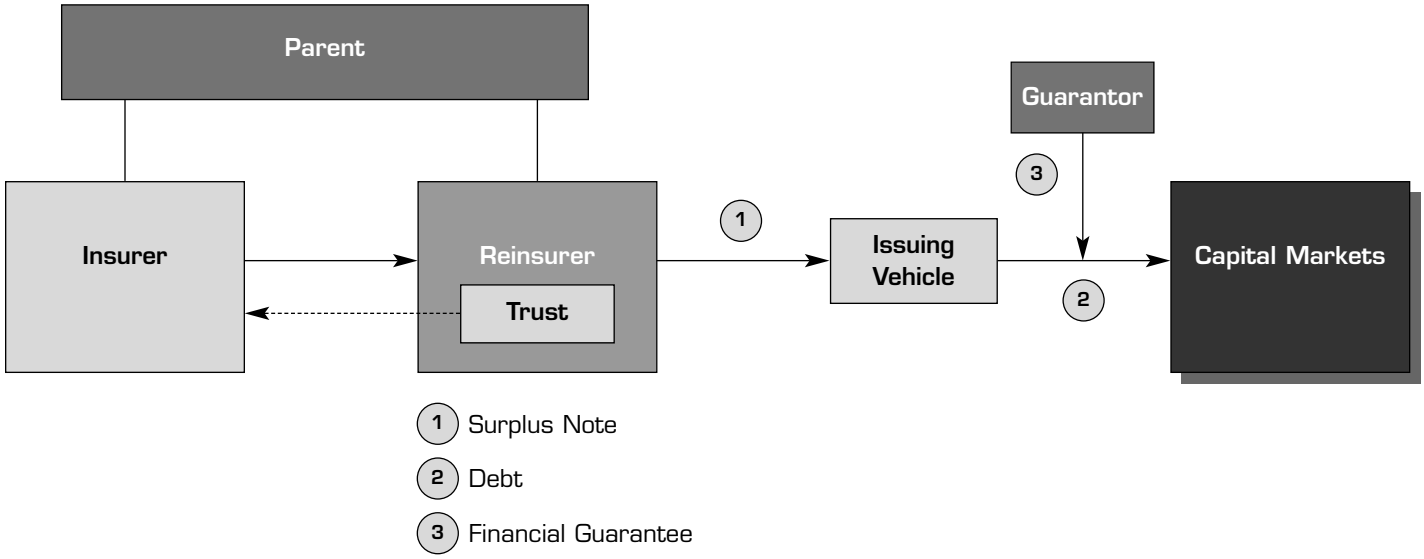


Figure 3: Securitization Using Rated Affiliate

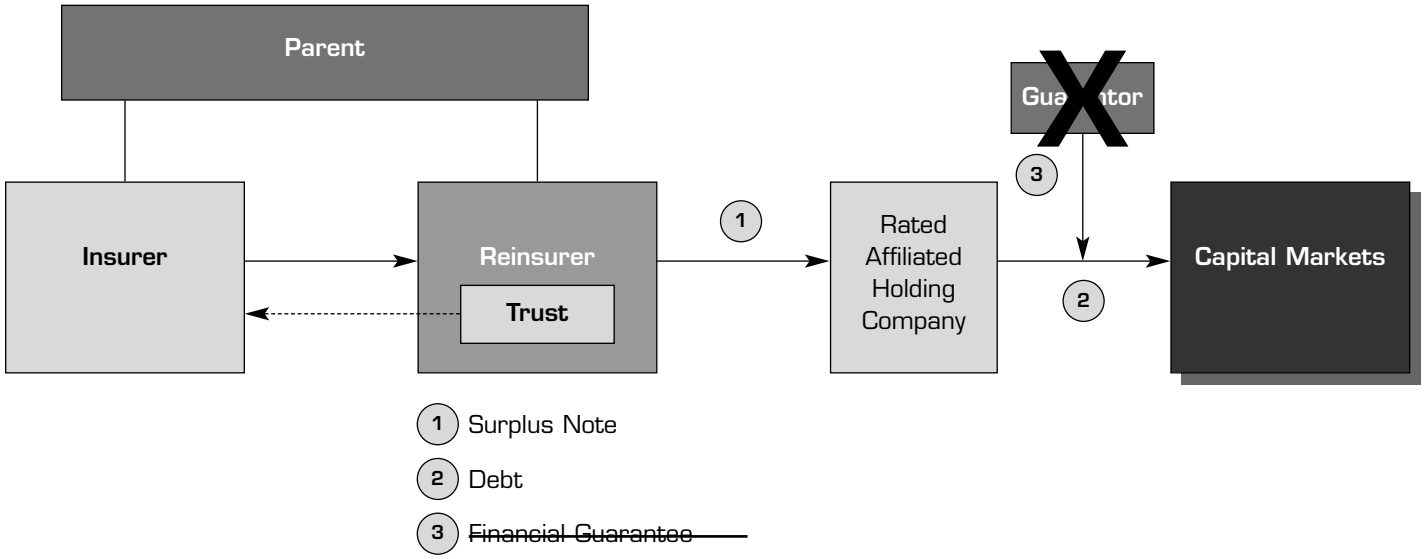
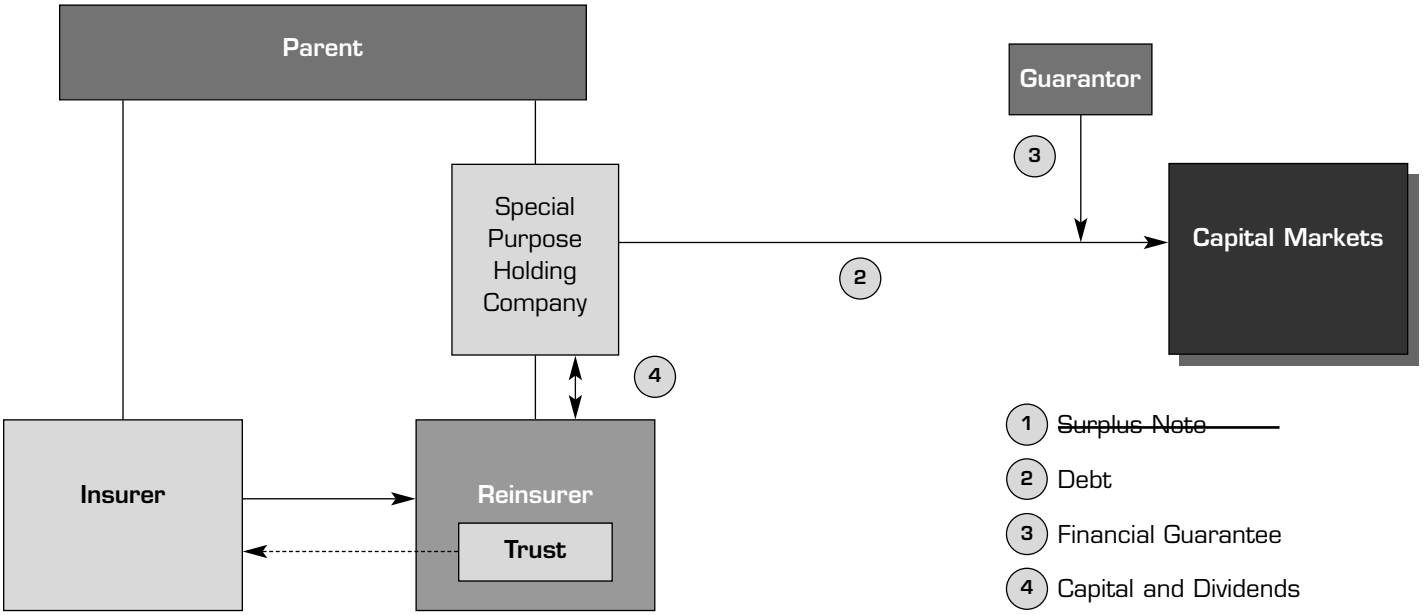


Figure 4: Downstream Reinsurer Securitization



An important consideration in making this choice is tax treatment. Management should consider not only where the reinsurer will fall within the organization from a capital and ratings standpoint, but also consider which tax group it will join. They should also consider what accounting basis they will adopt for the company to make sure that the anticipated tax effects will actually come about.

Securitization—The Advantages

Why is securitization so attractive? Securitization using surplus notes and a monoline guaranty is one of the few non-recourse approaches to addressing non-economic capital strain. In this case the guarantor is on the hook in the event that poor performance from the underlying block of business prevents expected debt service payments.

Securitization also offers financing for the entire size and life of the reserve hump. Some early transactions have funded the reserve buildup incrementally, issuing layers of debt as the reserves built up. Other approaches fund the entire reserve hump up front, in essence prefunding the ultimate strain. This offers the advantage of simplification, reducing the number of offerings required over time. However, it carries the risk of resulting in more funding than is actually necessary and increasing the overall cost of the deal.

Securitization—The Disadvantages

But securitizations are not a panacea. Securitizations involving surplus notes and guarantors are time intensive. As more transactions are completed, as the underlying blocks of business get better understood and as the requirements and deliverables are better defined, execution time will in all likelihood shorten. But currently nine to 12 months is still a reasonable target.

Securitizations are also difficult to manage due to the number of stakeholders involved. Figure 5 on page 34 lists a sample of these parties and their numbers. Each of these groups will enter the transaction with their own agendas and mandates, and their own sense of where the risks are—both with respect to the deal as well as to their professional duties to their clients. Managing these agendas to a common end can become a little arduous, particularly since many of the parties are not comfortable with insurance risk—certainly not as comfortable as professional reinsurers are.

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Figure 5: Parties Involved (Other than the Insurer and Capital Market)

Party Involved	# of Teams
Investment Bankers	Usually one
Ratings Agencies	At least two
Regulators	At least two
Guarantors	Usually one
Consulting Actuaries	At least two
Underwriting Consultants	One
Attorneys	At least three
Accountants	At least two

With all of these parties and the time it takes to execute these deals, execution risk also becomes a notable factor. A company can get fairly well down the path and discover that, for one reason or another, it no longer makes sense for its particular situation. The path to successful execution is not always obvious up front.

Because of the large fixed costs involved, having a sufficient volume of business available to put into the structure is important. If a company does not have critical mass, it must consider if and how it can accumulate a sufficient volume out of several years' issues and both the financial and mortality risks of doing so. Even after the securitization, the insurer needs to consider what to do with mortality exposure in excess of its retention, remembering that the external parties do not like to be exposed to risk.

A final consideration before proceeding with a securitization is the insurer's ability and willingness to provide documentation and data on processes for and controls over sales, risk selection (including exceptions), pricing, premium collection, claims settlement and experience studies. The guarantor and its advisors will want to see evidence (data) that the business has the characteristics and is of the quality that management has described ("show me, don't just tell me").

The Role of the Independent Reinsurer

Recall that all of these transactions have the same basic pieces to them—the insurer, the reinsurer and the capital market. There is no reason why the reinsurer cannot be independent of the insurer. In fact, there can be some advantages.

The professional reinsurer is in the position to aggregate business to critical mass. So for companies with smaller books of business, the reinsurer has the opportunity to pool that with others to build a sufficient volume of business to support a securitization.

In addition, the professional reinsurer can convert a potential on-balance-sheet issue to an off-balance-sheet solution for the insurer. They also may be able to provide better support for assumptions by virtue of their position with respect to multiple blocks of business. Unlike some of the other parties in the transaction, the professional reinsurer is in the risk business and is accustomed to evaluating, pricing and holding risk.

By translating the capital support need into a reinsurance solution, the professional reinsurer transforms the insurer's execution management to simply that of a reinsurance transaction. The more uncertain execution risk associated with providing reserve credit security passes to the reinsurer.

Conclusion

The path towards securitization as a solution for redundant reserve strain really has only just begun. The key argument for pursuing securitization usually involves separating the financing need from mortality risk transfer and focusing on the most efficient solutions for each.

The opportunities that securitization promises to provide are truly impressive for both insurers and reinsurers, but it will be some time still before all of those promises become a reality for all companies. As it stands today, there is still a premium to be paid for being one of the first companies to execute these transactions, limiting its scope to only the largest of companies. And the jury is still out on how future regulatory or accounting changes may affect the future attractiveness of securitization.

In the meantime, the industry still has a demonstrated reliable solution in the form of reinsurance. It is in the best interest of all parties for the reinsurer to clearly explain to its clients all the advantages and risks associated with tapping the capital market, and work together toward solutions that meet the client's current and future needs. ✹

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CONTINUING EDUCATION SECTION ACTIVITIES 2006

by Craig Baldwin

The Reinsurance Section Continuing Education Committee has been busy so far this year providing input to the various programs taking place during calendar year 2006.

At the upcoming Spring Life and Health meetings that will take place May 24–25 and June 20–22 respectively at the Westin Diplomat in Hollywood, Fla., John Nigh is the Reinsurance Section's Program Committee representative for the Spring Life meeting. Mark Troutman will be his counterpart at the Spring Health meeting.

There are three reinsurance-related sessions planned at the Life meeting:

- The Silent War—dealing with the new relationship evolving between reinsurers and their clients;
- The three Cs of the reinsurance quote and contracting process (constraint, combat and consensus); and
- Alternative forms of capital for use in reinsurance and M&A—which speaks for itself.

There are two reinsurance-related sessions planned at the Health meeting:

- Government Program Reinsurance Market Update—dealing with the pricing and underwriting issues and trends in catastrophic reinsurance of Medicare and Medicaid programs;
- Catastrophic Medical Claims Trends—to discuss trends in severity and frequency of various categories of catastrophic claims, including transplant, neonatal, trauma and others.

At the Product Development Symposium that will take place at the Hyatt Lake Las Vegas, June 26–28, the Reinsurance Section will be sponsoring a newly formatted embedded seminar on reinsurance. Please refer to the SOA Web site for more information. Dale Mensik is chairing this program.

The Section has also provided input to the program for the DI/LTC conference, which will take place at the Hyatt Grand Cypress in Orlando September 6–8, with the help of Barry Eagle and Tim Hale.

Plans are currently in the works for four reinsurance sessions at the Annual SOA meeting, which is to be held at the Sheraton Towers in Chicago, October 15–17. In addition to these sessions, the Section is planning a Section breakfast for the morning of the October 16. David Addison is chairing the planning for the Annual Meeting.

And, last, but not least, Bob Diefenbacher is serving as the section's representative on the Program Committee for the AHOU Annual Meeting, which will be held at the Mirage Hotel in Las Vegas, October 22–25. Bob will be heading up a specially targeted session on reinsurance for underwriters. ✺

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- Invitations to participate in section social/networking events
- Mailing/e-mail communications announcing upcoming research, projects, continuing education events and other activities

Participation in the Reinsurance Section is no longer limited solely to members of the Society of Actuaries! The section is now welcoming other actuaries and interested persons to participate in its activities. Applicants with interests in reinsurance areas relevant to the actuarial profession will be accepted for correspondent status. If you are interested in being considered for correspondent status, please complete the form below and submit it with a check for the processing fee. For those persons who are accepted, the processing fee will be applied to first-year section dues. Processing fees for applicants who are not accepted will not be returned.

Reinsurance Section Membership Application

Mail application and nonrefundable processing fee (by check payable to the Society of Actuaries) to:

Society of Actuaries
Attn: Mike Bell, Reinsurance Section Staff Liaison
475 N. Martingale Road, Suite 600
Schaumburg, IL 60173-2226

_____ **YES! Enclosed is my $20.00 processing fee. I would like to be considered for correspondent status in the Reinsurance Section.**

Name _____

Organization _____

Current Position _____

Reinsurance Involvement _____

I am a member of the following organizations:
_____

Mailing Address (Name) _____

City _____ State/Province _____

Country_____ Zip/Postal Code _____

Phone _____ E-Mail address _____

Fax _____