# Insurance Review
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# CHAPTER ONE Development of Insurance

Insurance is an idea as old as civilization, and as new as each fall's hurricane season. The basic idea of insurance is simple, but the way it has developed into the huge industry it is today and its function in the economy are not widely understood. Neither is its unique accounting system.

In order to grasp some of the complications of modern insurance, a brief overview can be helpful to anyone concerned with the industry, whether as a consumer, a supplier, or a professional accountant.

**Public Interest Involved**

Insurance has been held by the U.S. Supreme Court to be "affected with a public interest" and thus subject to government regulation. States have the chief responsibility for regulating the insurance industry. Because of state statutory requirements, insurance accounting differs somewhat from the generally accepted accounting principles used by the business community.

State approved reporting forms emphasize valuation of assets and liabilities for insurance companies on a liquidation basis rather than a going concern basis. Solvency is the primary consideration. The importance of fulfilling social goals in addition to business objectives, set out in the Supreme Court decision, is emphasized under this and other regulations that recognize the historically important role of insurance in economic development.

**Risk Coverage in History**

Greeks and Romans had insurance contracts, but the business of risk coverage is believed to be even older than that. In Babylon as early as 4000 to 3000 B.C. there was a fairly sophisticated banking system. Merchants took out loans to ship goods by caravan or from port cities. The early custom when such a cargo came to grief was to foreclose by selling the merchant and his family into slavery.

A more humane and profitable system gradually evolved. Lenders found they could charge premium interest rates on the loans and, by making enough of them, cover losses and produce a profit.

Such an agreement came to be called a "bottomry" contract. It was known in ancient Greece and among sea-going traders in other nations around it. Roman law recognized bottomry contracts in which agreements were drawn up and funds were deposited with money changers.

**Marine Insurance**

During the Middle Ages, marine insurance as a separate arrangement from premium interest on loans was developed in Venice and other Italian port cities. The ban on usury by the Catholic Church is believed to have influenced the separation. The oldest known written insurance policy, from Genoa, has a date of 1347. The word "policy" can be traced to the Italian "polizza," for a folded piece of paper.

Usually a group of men rather than one individual would offer coverage on a cargo. Each one would write his name under a list of the shipping risk items he was to guarantee. This custom is the origin of the term "underwriter."

Naturally such men looked for business in common meeting places close to docks in port cities. In England one such place was a coffeehouse owned by Edward Lloyd. The owner not only supplied meeting rooms and refreshments for the merchants, bankers, and sea-faring men who were his customers, he also collected shipping information for them from the docks and other places. This became "Lloyd's List," which is still being published. In 1769 Lloyd's became a formal group of underwriters for marine risks Lloyd's, London.

**Importance of Insurance**

The risk-covering business has grown in importance over 5,000 years because it works. Insurance today works for individuals, for families, for its suppliers, and for the economy as a whole.

Most people know from personal experience that having enough insurance can mean security while not having it can mean disaster. But as to just how and why insurance works, the average person does not have a very clear idea. In deciding what kinds of insurance policies are best suited for their needs, people usually rely on insurance agents for information. As for the insurance industry's overall importance to the U.S. economy, that is not a matter to which the public gives much thought.

**Scientific Principles**

Economics is the science of wealth, and insurance is an applied division of economics. It works because it is based on scientific principles.

The basic purpose of insurance is the protection of wealth. This purpose is easy to understand when the insurance is protecting something tangible, like a building or a ship. The goods being stored in the building or moved in the ship also are tangible. All these things are inevitably exposed to risk. What their loss would cost the owner is covered by property and casualty insurance, the oldest form of risk coverage.

Life insurance is a more recent development. The idea of putting a dollar value on life itself is not as easy to think about as insuring a building. It requires a realistic approach to the protection of human life values through their expression in terms of dollars.

**Pooling of Risks**

The basic function of insurance is the spreading of risks among many individuals. Each one pays a relatively small amount in premiums for protection against potentially large losses.

Insurance has as its basis the relative-frequency approach to probability. This is sometimes referred to as the law of large numbers, or in non-technical terms, the law of averages. It is scrupulously observed by professional insurance people and professional gamblers. They have in common an understanding of the mathematics of probability. They also have faith that the law of large numbers will continue to operate in the future as it has in the past. Casino operators figuring house odds and actuaries figuring insurance rates base their calculations on that assumption.

The difference between gambling and professional risk coverage is that individuals expose themselves to gambling odds of their own free will, while those who do not choose to gamble still face risks in the ordinary course of life. While civilization has largely eliminated risks like those posed by the cave bear and the wolf, it has substituted many more.

Protection against disastrous risks is the business of the insurance industry. This protection is achieved by spreading risks among large numbers of people facing similar situations.

**Development of Insurance in the United States**

At the beginning of the nineteenth century there were only five million people in the United States, and nine-tenths of them were farmers. There were just six cities with a population of more than 8,000--Philadelphia, New York, Boston, Charleston, Baltimore, and Salem.

Under these circumstances it was up to each family to provide its own financial security. The idea of buying insurance was practically unheard of.

An ordinary individual's life work consisted of producing tangible things to fill the needs of family members. Food came from crops, herds, and game in the nearby woods. Fuel came from the woodlot. The home-built house provided shelter for the family, including those too young, old, or sick to work. But major changes were coming.

**Development of Life Insurance**

Along the eastern seaboard there were people who depended on trade rather than farming to make a living. A farmer took his chances from season to season with the weather, but a merchant sending out a cargo on a ship was risking a loss that could mean ruin for a lifetime.

In the New England coffeehouses where seafaring men gathered, the ancient system of risk coverage

through marine insurance was practiced by colonial underwriters. Early contracts were concerned only with accidental loss of property. The underwriters then began to offer policies covering the risk of capture by pirates. The next step was to add policies covering death during voyages. For landlubbers, however, life insurance was not yet an idea whose time had come.

**Industrial Changes**

The first known life policy was issued in England in 1583, but the idea was not widely accepted until after the Industrial Revolution. By the late 1700s this development had changed the very foundations of western society, splitting apart production and consumption.

In the rural, self-sufficient social structure of colonial America, families and friends were responsible for the security of each individual. Then as industries grew up, people moved from farms to cities in order to find work. Factories and their payrolls meant a cash economy. Cash income required savings for individual security. In the place of self-sufficient family units producing and consuming their own necessities, there grew up a great complex society in which goods and services were produced for sale. People who came from the farms to the growing cities no longer had their own food growing outside the door. They were far away from relatives who once would have taken care of them. They did not barter their services, but were paid in cash.

Under these circumstances, the idea of using cash to buy security began to make sense for those who felt a responsibility to provide for their own future and that of their families. Modern insurance developed from the new industrial democracy, and continued to grow with it.

**First Company Founded**

The first life insurance company in this country was the Presbyterian Ministers' Fund, founded in 1759. Individual insurers like the early marine underwriters continued to operate, but growth of the insurance business as a whole was slow in the eighteenth century. The Insurance Company of North America was established in 1794. Still, by 1800 very few Americans had life insurance or felt the need of it.

The War of 1812 greatly speeded up the industrialization of America. European imports were no longer to be had, and factories began to spring up in New England and the Middle Atlantic States. Cities grew around them as young people came in from the farms to work. Between 1810 and 1860, while the population of the United States was growing by 334 per cent, the number of people living in cities and towns went up by more than 1,000 per cent.

**Growth of Life Insurance**

The increase in the size of cities meant an increasing need for insurance. Heads of families who wanted to provide for surviving dependents no longer had family farms upon which to fall back. They had to use part of their cash income to buy life insurance if they wanted to leave something to their families.

In response to this need, many life insurance companies were formed in the early part of the nineteenth century. As might be expected in a new, fast-growing business, there were failures. Companies that were poorly financed soon disappeared. The ones that could be depended on prospered.

There was a major difference between these successful firms and the early marine underwriters. The coffeehouse insurers often disputed claims or were unable to pay even the ones they acknowledged. Successful and well managed insurance companies could be relied on to meet the obligations they had undertaken.

When stock companies began to be organized in the early 1800s, it became easier to operate the insurance business on a systematic, dependable basis. But the idea of life insurance was still a comparatively new and unfamiliar one. By 1840, the total of life insurance in force in the United States was only $4,690,000

**Gold Rush**

Then came the start of an explosive era. The 1840s boomed. Gold was discovered in California. Canals and turnpikes linked the Atlantic coast with the rest of the country.

The first huge wave of Irish, German, and other European immigrants arrived. Texas had joined the Union,

and the war with Mexico added the rest of the great Southwest to the United States. Population jumped 32 per cent from 1840 to 1850. Much of that gain came in industrial areas.

With the rise of urbanization and industrialization, the popularity of life insurance grew. Two important changes in the life insurance business itself contributed to the growth mutual companies were started, and the agency system developed as more aggressive sales techniques came into use.

**Development of Mutual Insurance**

In England, mutual life insurance companies were well established. The idea of mutuality had been carried over to the fire insurance field in the United States. The first American life mutual, however, did not begin operations until 1843. It was the Mutual Life Insurance Company of New York, founded by Morris Robinson, a former Canadian banker.

Other mutual companies soon followed. New England Mutual Life Insurance Company began issuing policies later in 1843, State Mutual in 1844, Mutual Benefit and New York Life in 1845, Connecticut Mutual in 1846, and Penn Mutual in 1847. Many more came later.

**Sales Promotion**

Early insurance companies had waited for customers to come to them. Now the new mutuals and the stock companies with which they were in competition began the aggressive marketing of insurance. Circulars and advertisements in newspapers and magazines set forth the advantages of life insurance. An army of new agents fanned out seeking prospects.

These agents generally had no training and no formal contracts with the companies they represented. About all the new agent had was a form sheet with a rate and commission schedule and a list of his duties. The usual commission was five or ten per cent on first-year premiums and five per cent on renewals for a limited period.

Even in the booming early 1800s, selling life insurance was not easy. Most people still were not familiar with the idea, and the cost of insurance compared with today's rates was very high in proportion to income. A factory worker at the time was earning $1.50 a day. The cost of a participating policy at age 30 was $25 to $30 per $1,000. Most companies set policy limits between $5,000 and $10,000, so the agent had no chance to write a large policy even for a prospect who could afford one.

**Insurance Totals Grow**

In spite of limited coverage and high cost, sales of life insurance policies continued to accelerate. Insurance in force in this country reached $97,100,000 by 1850. In the next ten years it grew to $173,300,000. The increase over two decades was more than 3,000 percent.

The Civil War did not interrupt the trend. Insurance in force was increasing at a faster rate than ever by the time the war ended. In the postwar period the growth rate reached 50 per cent a year. Twenty-four new companies were formed in 1866 and 1867. The number of companies reporting to the New York State Insurance Department rose from 17 in 1862 to 71 in 1870. By the end of the 1860s, insurance in force reached two billion dollars, an enormous figure for those days.

**New Mortality Rates**

Several factors accounted for the strength of the life insurance business at mid-century in its first great period of growth. Sheppard Homans of Mutual Life, having discovered that American mortality rates differed from those in England, produced the first American Experience Mortality Table. In this country, mortality was higher at younger and older ages and much lower in between than in England. This table was in use for three quarters of a century.

New York Life first recognized nonforfeiture provisions as the right of a policy holder in 1860, and the application of this principle became widespread. Fraternal insurance through beneficial societies imported from England, such as Odd Fellows, began to be important.

The general agency system took hold in the early 1860s. By the middle of the decade it was the generally accepted method for selling insurance. Level premium whole life policies proved popular.

**Postwar Crisis**

The Civil War had brought unprecedented demand for all kinds of manufactured goods, and after the war American enterprise continued at a fever pitch. New industries sprang up. Railroads crossed the continent and cables crossed the oceans. Coal, copper, and iron mines fed the factories. America was on its way to becoming the industrial colossus of the world.

In the excitement, attitudes changed. Business and political life no longer were governed by the ethical standards once taken for granted. Tax and other scandals rocked the Grant administration. Business was drawn into wildcat schemes, stock-watering, and embezzlement.

The life insurance business, now beginning to play a major role in the social and economic life of the country, naturally was influenced by the spirit of the times. Many practitioners forgot or never knew that life insurance had been called "a great cooperative scheme . . . with unlimited liberating possibilities, which would alleviate, even eliminate, human distress." They concentrated on achieving personal power and prestige through success in business.

As a result, in an uncanny preview of the S&L debacle of a little more than century later, sound business practices were often ignored. Commissions were recklessly raised, exaggerated advertising claims were made, and some companies built themselves ornate offices costing more than their total assets.

Risks were underwritten carelessly and unearned dividends were declared. Methods of premium and reserve calculations were used improperly. There were even attempts to frighten enough policy holders into forfeiting so liabilities could be scaled down to somewhere near the level of assets.

Publicity about these abuses coming simultaneously with the depression of the 1870s brought about what has been called the most trying period in the history of American life insurance. The shakier companies went down first and others followed. By 1882, more than half of the life insurers in business in 1870 had failed, leaving only 55 companies operating in the United States.

**Introduction of Regulation**

A long campaign waged by Elizur Wright (1804-1885), who came to be known as the father of life insurance as it now exists in America, resulted in the passage of state insurance laws regulating reserves and asset management. These were to be strictly enforced by newly established state insurance agencies.

In the early part of the nineteenth century, the few rules governing the life insurance business were written into the charters of individual companies. State regulation of the insurance industry in America up to that time was almost unknown. Beginning in the 1840s, the hit-or-miss methods used by most insurance companies to calculate their reserves became the concern of Wright, a fiery newspaper editor, schoolteacher, and abolitionist. He thought the companies should be required by law to maintain adequate reserves.

Through enormous efforts involving nearly 200,000 calculations--long before the age of computer-Wright produced a compilation of net valuation tables that showed what reserves should be held at the end of each year during the life of various policies. He lobbied a version of his legal reserve principle through the Massachusetts legislature almost single-handedly in 1858.

**State Regulation**

After his bill became law, Wright was appointed to head the state's insurance department, which had been organized three years earlier. This combination of events began effective state regulation of life insurance in the United States.

Similar legislation was soon passed in other states. Within ten years, 35 states had set up special insurance departments or appointed special insurance supervisors.

Closer official supervision and the disappearance of weaker companies during the depression of the 1870s combined to restore public confidence in the insurance business by the 1880s. Economic recovery was under way and industrial development was expanding again. Money in circulation increased.

The population of the country soared from 17 million to 50 million between 1840 and 1880. Much of that increase came in the cities, where the need for life insurance was best recognized.

**Westward Expansion**
The western part of the country was rapidly being settled. The insurance industry also was broadening its horizons. Older companies expanded into the west and new ones were established to offer protection to the growing population of the area as cattlemen, farmers, and miners followed the frontiersmen.

More and more after 1880, life insurance provisions were liberalized. As people began to travel more, companies starting with Home Life of New York in 1886 removed travel restrictions on policies they issued.

Cash and surrender values, 30 days grace on premium payments, and statements of incontestability were added. Connecticut General pioneered the insuring of substandard risks starting in 1865. The first policies providing waiver of premiums in case of total disability of the insured were issued in 1896.

In addition to these changes in older types of insurance, there was a new development. Industrial insurance to meet the needs of low-income groups was introduced by the Prudential in 1875 and soon became widely accepted.

Improvements and expansion pushed the total of insurance in force in this country from $1,522,000,000 in 1880 to $3,522,000,000 in 1890. By the end of the nineteenth century the figure had risen to $7,500,000,000 and the American life insurance business was the largest in the world.

**New Investigation**
Growth and boom times again brought difficulties. At the turn of the century financial developments were proceeding at a frenzied pace, and questionable business practices exposed by "muckrakers" caught the public's attention.

Life insurance companies, by now custodians of much of the nation's wealth, came in for their share of criticism. There were many reputable firms, but there were also those which were not, and public demand for investigation of the entire business became urgent.

In 1905 the Armstrong Investigating Committee was set up to look into the life insurance business in New York. Its chief counsel was Charles Evans Hughes, later governor of New York and chief justice of the Supreme Court. He made it clear that the committee's aim was not to attack the entire life insurance industry but to strengthen and protect it through needed reforms.

Recommendations by the committee led to the New York Insurance Code, adopted in 1906. Responsible insurance companies backed the regulations. These included supervision by the state insurance department of the election of company officers, outlawing of the deferred dividend system, prohibition of investments in common stocks (later modified), and limits on the amount that could be spent to secure new business.

For a period after the Armstrong investigation new insurance fell off sharply, but as public confidence was restored the industry moved ahead again. Government life insurance during World War I gave the nation a favorable experience with protection.

**New Developments**
Group insurance was introduced. Disability clauses and double indemnity benefits were included in policies, and optional settlements of policy proceeds were developed.

Use of life insurance for business purposes grew steadily. The cost of insurance decreased with favorable mortality experience, high interest rates, and few capital losses. New business, assets, and insurance in force steadily increased. A record $20 billion in new insurance was written in 1929 alone, and by that year insurance in force reached and passed $100 billion.

**Crash and Depression**
From the highest peak the economy went into its steepest slide. The stock market crash of 1929 was followed by the Depression of the 1930s. The national income had been cut in half by 1932. Stocks were worth hardly more than a tenth of what they had been in 1929, and about 13 million people were unemployed. Suicides rose to 30 per cent above normal.

Naturally the effect on the insurance business was severe. The amount of new insurance written dropped sharply in 1931 and 1932, until for the first time in a generation the total of insurance in force showed a decrease.

Mortality losses rose with the suicide rate. Disability claims went up. Policies lapsed and were surrendered. With defaults in mortgage payments and lower interest rates, insurance company earnings showed a sharp decline.

Compared with most businesses in the country, though, life insurance was still in good shape. Only 20 companies, none of them major, out of a total of about 350 went into receivership. A little more than one per cent of the total insurance in force was involved in these failures, and even this amount was reinsured by solvent companies so there was little actual loss to policy holders.

**Search for Security**
The Depression experience resulted in an enormous desire for financial security on the part of Americans. In the long run this trend proved a benefit to the life insurance business. Passage of the Social Security Act in 1935 and its amendment in 1939 to provide survivors' benefits brought a broad-based recognition of the importance of personal security.

The immense volume of government administered life insurance thus provided did not cut into the demand for more private coverage. By improving public understanding of the value of protection for financial security it helped increase the sale of privately issued policies. As a result the increase in the amount of life insurance in force went from steady to spectacular.

New policies such as the family plan were introduced. Low-cost group insurance tripled in ten years. Annuities, insured pension plans, and credit life insurance all added to the total and made life insurance useful to more and more segments of the population. Americans increasingly came to use life insurance as a major tool in building a secure society.

Insurance rates are based on scientific principles. To compute policy rates low enough to encourage the spread of the benefits of insurance and yet high enough to give margins of safety for the companies providing it is a science resting on hundreds of years of study. Records have been kept, monitored, and updated over those years to establish workable rates.

Life insurance companies over the years have placed increasing emphasis on training and education for their agents. Today the major portion of the life insurance business is handled by full-time professionals.

Individual companies offer training courses of six months to two years. The Life Underwriter Training Council also provides courses. Under the auspices of the American College of Life Underwriters an advanced training program is available in colleges, insurance company classrooms, and study groups. This organization, founded in 1927 to raise the standards of insurance education, designates its graduates as Chartered Life Underwriters (C.L.U.) to identify them as fully trained, well informed professionals.

These advances in quality have contributed to the continuous rise of total life insurance in force, which by the 1980s had reached the enormous sum of three trillion dollars, more than 25 times what it was in 1940.

**Savings and the Economy**
In addition to this massive individual protection, life insurance plays another basic role in society itself. Life insurance funds represent the savings of millions of Americans, and these funds are poured back into the economy as investments. Insurance thus provides financial stability both for individuals and for the nation.

In early America the life insurance business helped buy bonds to pay for canals and turnpikes that tied the

country together. During the Civil War the industry made huge purchases of government bonds to bolster the credit of the Union and stimulate industry. As nineteenth century inventions provided new conveniences, insurance funds supported the expansion of public utilities. Electricity, water, gas, telegraph, and telephone service became available nationwide.

Housing crises after the Civil War and World Wars I and II were eased with mortgage loans provided by life insurance funds. Loans to farmers put machinery to work producing crops that have helped feed the world, even with the decrease in rural population as cities continued to grow.

**Industrial Expansion**

Most of all life insurance dollars were used to fuel American industry. The development of an industrial society brought about the life insurance business and in turn that business became a great source of capital for industrial expansion.

Insurance companies buy industrial bonds. They free corporate capital for various uses by sale and lease-back arrangements. They invest directly in industry through stock purchases.

This ingenious combination of insurance functions, protecting individuals and investing their savings in the economy, has made possible the complex industrial society we have today. Insurance serves as an indispensable security system both for individuals and for their institutions.

**Structure of the Insurance Industry**

With some five times as many companies in business as in the 1940s, the life insurance field today is highly competitive. Most life insurance is issued by legal reserve companies of two basic types. These are mutual companies owned by their policy holders and stock companies owned by stockholders.

Newer and smaller firms providing coverage in a single state or in a limited few have led to a spreading of company home offices across the nation until there is at least one in every state. This dispersal of companies has made easier the distribution of life insurance to families all over the country.

**Life/Health and Property/Casualty Premium Totals**

**Life/Health ($000)**

| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Life Insurance Premiums | $ 122,812,480 | $ 130,546,216 | $ 125,958,978 | $ 133,829,367 | $ 151,352,648 |
| Annuity Premiums & Deposits | 326,985,000 | 339,914,846 | 279,434,360 | 352,823,672 | 324,034,800 |
| Accident & Health Premiums | 151,068,078 | 151,396,375 | 153,305,130 | 156,634,527 | 158,755,638 |
| Credit Life & Credit A&H Premiums | 1,556,674 | 1,556,674 | 1,445,214 | 1,388,591 | 1,382,988 |
| Other Premiums & Considerations | 2,247,325 | 2,247,325 | 2,345,600 | 2,554,791 | 2,497,634 |
| **Total** | **$ 604,669,557** | **$ 625,661,436** | **$ 562,489,282** | **$ 647,230,948** | **$ 638,023,708** |

**Property/Casualty ($000)**

| | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| Personal P/C Direct Premiums | $ 250,654,728 | $ 260,931,593 | $ 272,367,335 | $ 287,272,384 | $ 300,054,004 |
| Commercial P/C Direct Premiums | 235,982,944 | 247,128,276 | 259,943,105 | 270,997,951 | 279,803,539 |
| Accident & Health Direct Premiums | 8,572,313 | 8,424,278 | 6,701,202 | 5,766,660 | 6,142,327 |
| **Direct Premiums Written** | **502,011,305** | **523,914,193** | **546,334,118** | **570,782,303** | **591,758,049** |
| Net Reinsurance Premiums | (60,036,358) | (62,959,506) | (64,406,185) | (68,165,441) | (71,530,151) |
| **Net Premiums Written** | **441,974,947** | **460,954,687** | **481,927,933** | **502,616,863** | **520,227,898** |
| Change in Unearned Premiums Reserve | 3,644,385 | 7,917,132 | 9,853,047 | 9,095,596 | 8,395,501 |
| **Net Premiums Earned** | **$ 438,330,562** | **$ 453,037,555** | **$ 472,074,886** | **$ 493,521,266** | **$ 511,832,397** |

**Market Segments**
The U.S. insurance industry is generally divided into two market segments: life-health and property-casualty. The two market segments are themselves divided into categories called "lines of business", examples of which are:

- Fire, farm-home-commercial multiple peril, earthquake, and auto for property/casualty, and,
- Ordinary-group-industrial life and annuities for life health insurers.

There are various methods for selling insurance or bringing the product and consumer together for their common benefit. Insurers employ actuaries, claims adjusters, underwriters, and office personnel, but until the insurance policy is profitably sold, there is no chance for survival of the insurance company in the market system. An efficient marketing system is necessary. Life and health insurers use three basic methods to bring the insurance product to market:
General Agency System- The general agent is an independent businessman who represents only one insurer. In charge of a specific territory, the general agent is responsible for hiring and training of new agents. Business is done on a commission basis. The insurer may provide an allowance for training new agents and for overhead or office expenses.
Branch Office System- Also known as the managerial system, it is used for the sale of life insurance products. Branch offices are established in various areas. The branch manager is considered an employee of the insurer and is paid a salary plus bonuses based on the volume of business generated. Under this system, the insurer pays the expenses of the branch office, including the development costs associated with new agents.
Direct-Response System- This is a marketing system where life and health insurance is sold without the services of an agent. Customers are approached through television, radio, print, or other advertising media. The services of the agent are minimized. The life and health insurance products promoted usually are easy to understand and require relatively low premium outlays. These products include accident policies, hospital indemnity, and basic term insurance.

Property and Liability insurance use four basic types of organization:
Independent Agency System- This system has several characteristics. The agent is an independent businessperson who represents several insurers. The agency owner is authorized to write business on behalf of these insurers and in turn is paid a commission based on the amount of business produced. The agency owns the renewal rights to the business written. When a contract comes up for renewal, the agent can place the business with another insurer. The independent agent is compensated by commissions that vary by line of insurance.
Exclusive Agency System- The agent represents only one insurer or group of insurers under common ownership. The agent is prohibited from representing other insurers. The exclusive agents do not usually own the renewal rights to the policies they sell. Exclusive agency insurers generally pay a lower commission rate on renewal business than on new business. This creates a financial incentive for the agent to write new business. The insurer provides support services to new agents, often starting them out as salaried employees before allowing the agent to venture forth on a commission basis.
Direct Writer- A direct writer of insurance differs from an exclusive agent in that the agent/salesperson is an employee of the insurer and not an independent contractor. Financial remuneration is generally on a salary-plus-bonus basis.
Direct-Response System- This is an insurer who sells through mass-media, with no agents being used to market the product. This method has several advantages to property/casualty insurers. Selling expenses are lower. Market segmentation can be more precise through direct marketing and underwriting more selective. The insurance sold must be limited to simple lines such as automobile insurance. The consumer may benefit in that the absence of an agent and selective underwriting results in lower costs. This can also be seen as a disadvantage in the lack of personal service from a trained and knowledgeable agent.

The distinction between life insurance marketing and fire/casualty (property/casualty) marketing systems is breaking down as the trend toward multiline selling continues. Multiline selling means the agent sells more than one line of insurance.

**Insurance Business Organizations**
In the insurance business and related fields, organizations have been an important source of strength to practitioners. They have served as a way to exchange ideas and information in order to solve common problems, and have stimulated competition in the industry which has served the interest of the public.

Some of the more important organizations include the American Life Convention, American Society of Chartered Life Underwriters, Health Insurance Association of America, Health Insurance Council, Health Insurance Institute, Home Office Life Underwriters Association, Institute of Life Insurance, International Association of Health Underwriters, Life Insurance Management Association, Life Insurance Association of America, Life Insurance Medical Research Fund, Life Office Management Association, Life Underwriter Training Council, Million Dollar Round Table, National Association of Underwriters, and Society of Actuaries.

There are other groups which make contributions to the effectiveness and public service of the life and health insurance business, including organizations of company specialists in medical, legal, investment, public relations, accounting, and statistical fields.

The American College of Life Underwriters is an independent educational institution serving life and health insurance. It is a non-profit organization which provides a variety of college level courses in life and health insurance, carries out research, and acts as a national examining board for those seeking the designation of Chartered Life Underwriter (C.L.U.)

For those with a scientific interest in insurance, the American Risk and Insurance Association is devoted to advancing the science of risk and insurance through education, research, literature and communications. State supervisory officials in insurance through the National Association of Insurance Commissioners have an exchange medium for ideas and trends. This group aims for as much standardization as possible of insurance regulations by states.

These organizations together have made an important contribution to the advancement of insurance in the interest of the policy holders. They have intensified competition among individual companies while also providing the framework for extensive cooperation in research and methods.

**Contributions to the Economy**

Both the size of the companies' financial operations and the unique way in which its investment funds are channeled give insurance its special importance in the nation's economy. Insurance companies both as investors and employers make vital contributions to the health and stability of the country as a whole. It has been estimated that one out of eight individuals in the work force today is employed in an insurance-related activity.

In their role as insurers, providing money when the family most needs it, life and health insurance companies make a direct contribution to the health and stability of the basic unit of society. The total of benefit payments nationally is impressive, but the individual or family share of this total is more than impressive--it is a lifeline.

Cash value life insurance is one of the most important long-term savings arrangements in this country, providing billions of dollars of financial resources for individual families while producing massive investment funds for the economy as a whole.

It was apparent by the turn of the century that fraternals would have to adopt scientific methods both in setting rates and in providing reserves if they were to maintain financial solvency.

**Mutuals and Stock Companies**

Although the typical mutual insurance company is older and larger than the typical stock company, most individual insurance companies in the United States today are stock companies.

A mutual company's funds are held for the exclusive benefit of policy holders, who own the company. These companies issue participating policies, which pay annual dividends to policy holders, reducing the cost of the policy from the original premium amount.

For a stock company, financing is provided by its stockholders. They assume the responsibility for management and expect to receive a return on their investment.

Stock companies issue nonparticipating policies. The premiums for these policies are lower than for

comparable policies which pay dividends, and costs are fixed for the life of the policy. Some stock companies issue both types of policies, participating and nonparticipating.

Assessment companies, now relatively few in number, issue policies on which premiums are set and can be varied according to the companies' experience. Fraternal groups operate under special laws.

**Development of Fraternals**

Policies issued by fraternal organizations made up an important part of the developing insurance picture in the United States in the nineteenth and early twentieth centuries. Like marine insurance, this type of policy had historical roots. Religious and fraternal societies under the Roman Empire had paid benefits when their members died. Guilds in the Middle Ages took care of their own.

The first fraternal insurance known in the United States was issued in 1868 by the Ancient Order of United Workmen, founded by John Jordan Upchurch at Meadville, Pennsylvania. Earlier fraternal societies are believed to have existed in the country, but there are no records to show that they undertook to provide insurance coverage on the lives of their members. Social changes during the latter half of the nineteenth century brought about the rise of fraternal insurance.

After the Civil War, the United States was still largely rural. People who moved from the farms to the growing cities usually became members of the working class. The middle income group of salaried workers and independent businessmen was much smaller than it is today.

Two segments of the population, labor and farming, accounted for a major percentage of the people living in the United States. Members of these two groups usually were not protected by life insurance. They were, by and large, in lower income brackets and could not afford ordinary life policies, the only protection offered at that time by private companies.

Premiums were payable annually, semiannually, or quarterly on policies with a minimum size of $1,000. Most working people simply found ordinary life insurance beyond their reach.

**Class Antagonisms**

The prevailing attitude of suspicion and distrust on the part of the farm and labor segments of the population toward large corporations at that time was reinforced by the nature of the private insurance business after the Civil War. Level premiums, reserve accumulations, and nonforfeiture values were difficult to understand and induced distrust in many people toward the insurance industry.

Commercial insurers found themselves confronted with suspicion and skepticism. The failure of some private insurance companies in the depression of the 1870s increased these reactions.

In this environment, the need for protection on the part of lower income groups naturally brought about the introduction of other forms of life insurance protection. One was industrial life insurance. Another, combining protective and social functions, was fraternal life insurance.

Social activities for lower income groups in the late nineteenth century were few. There were no movies, no radio or television, not even phonographs. Social visits were limited by transportation difficulties.

It was Upchurch's idea when he founded the Ancient Order of United Workmen to offer life insurance through an organization in which all participants were connected by social bonds. Members of his organization were mechanics and artisans. They had a trade in common.

Objectives set out in the framework of the constitution of the Ancient Order of United Workmen, representative of fraternals at that time, were as follows

1. To unite into one common brotherhood all persons employed in the mechanical arts.

2. To create a means of prompt and effective cooperation in matters of common interest.

3. To oppose inimical legislation and to foster favorable legislation.

4. To establish libraries and provide for lectures and other means of education.

5. To employ all legitimate means to establish and to maintain harmony and equity between employers and employees.

6. To ameliorate the conditions of unfortunate, afflicted, and oppressed members.

7. To establish an insurance fund out of which not less than $500 should be paid to the legal heirs of a deceased member.

The purpose of the organization was thus much more comprehensive than providing insurance benefits. In the growth of the fraternal concept, the social organization was very important.

The social group or lodge had a membership organized on a restricted basis, typically race, occupation, sex, or religion or a combination of those elements. Modern Woodmen of America, the Order of Railway Conductors of America, the Free Sons of Israel, and the Daughters of America are a few examples of the societies of the time.

Ritualistic ceremony was an important aspect of lodge organization. Colorful and complex rituals, costumes, and initiation ceremonies served to give the various groups a sense of individuality, to further the ties between members, and to attract new members.

Group cooperative dinners, picnics, Christmas parties, athletic contests, and dances were held in addition to regular weekly or monthly meetings. In that sense the groups were similar to social and special interest organizations of today, but they were more important in the lives of their members because of the scarcity of other forms of recreational activity.

The fraternal organizations incorporated welfare, benevolent, and charitable works into their programs, accepting responsibility for members and their families. Less fortunate members were provided with hospitals, sanitariums, visiting committees, and financial help through extra funds contributed periodically by members in addition to insurance assessments. The lodge organization, geographical proximity of members, and the bond established between individuals in the fraternal association combined to make members willing to help each other in time of need.

**Organization of Fraternals**

Although the local group is still the foundation stone of the fraternal society of today, some have state organizations and most have national officers to carry out the objectives of the organization. Delegates elected from the local groups choose the state and national officers.

This representative form of government from the beginning of the fraternal movement was a distinguishing factor between it and private life insurance companies. Fraternals are required by state statutes to maintain a representative type of government, and voting by proxy usually is not permitted.

National groups usually are required to meet at least once every four years to elect officers and set policy. Societies which do not have either state or national organizations maintain a ruling board of directors or trustees which are elected by member groups or by a direct vote of the membership.

**Assessment Plans**

Death benefits for members of fraternal societies were provided at first by the uniform post-mortem assessment plan. In the Ancient Order of United Workmen, when a member first joined he contributed an initiation fee of $1.00. Beneficiaries of the deceased member received a payment of $1.00 per active member.

Each surviving member contributed a maximum of $1.00 when an active member died. The upper limit for the death benefit was $2,000. If the membership was more than 2,000, each member contributed a pro rata share of $2,000.

The people who did not trust reserves maintained by private insurers found this idea of assessment insurance appealing. They liked not having to pay into the reserve of a commercial insurance company. Uniform assessments, with each member contributing the same amount, also reinforced the idea of fraternalism.

**Young Members Needed**

There were defects, however, inherent in the assessment idea from both the financial and marketing standpoints and they soon became apparent. A society operating on a postmortem uniform assessment basis was burdened with collections when many deaths occurred during a year. There were expenses which developed into a significant portion of the premium.

Most important, however, was a lack of reserve to offset high mortality costs in a society with an increasing average age. To continue to function successfully, an assessment type of operation needed to have young members joining at a rate which would maintain a constant age distribution. This was the theory, but in actual fact it turned out that new members were not attracted by a uniform rate of assessment.

The cost per year for protection rose as the average age of the group increased and assessments became more frequent. The younger members realized that they were paying an amount that was out of proportion to their degree of risk, and they started to drop out.

This loss combined with the difficulty in attracting new, younger members forced societies to disband, merge, or adopt a scientific method of computing their premiums. The idea of graded assessment contributions was developed to attract and hold members dissatisfied with the uniform assessment plan.

**Assessments Graded**

On the graded assessment scale, members' assessments were based on the age of each member when he entered the society. The premium set by age of entry was presumed to remain level for the duration of the member's life. If a man entered when he was between 21 and 25, for example, he would pay a $1.00 a month assessment for the rest of his life, but if he entered at age 40, the monthly rate would be $1.75.Graded assessment plans, however, ran into the same problems that had affected uniform assessment operations. For a time after graded assessments went into effect, membership increased rapidly and provided a younger age distribution with an accompanying lower mortality rate.

Inevitably, as the average age of members in societies which had adopted the new plan increased, mortality costs again rose and financial problems reappeared. It was apparent by the turn of the century that fraternals would have to adopt scientific methods both in setting rates and in providing reserves if they were to maintain financial solvency.

Recognizing their problems, twelve fraternal benefit societies joined in the National Fraternal Congress. In 1895, for the first time, statistics of 25 commercial companies and 27 fraternal benefit societies were compared in tabulated form to produce the National Fraternal Congress Table of Mortality.

Meetings between the Fraternal Congress and the National Association of Insurance Commissioners over the next several years resulted in legislation which had the effect of putting the fraternals on a sound actuarial basis and starting them on a new chapter in development. The two groups later cooperated to propose uniform state regulation of fraternals by means of a model code approved by both organizations in 1955 and updated in 1962.

**Code Adopted**

The Uniform Fraternal Code was adopted by a number of states in its entirety and by others in part. It defined a fraternal benefit society as follows:

"Any incorporated society, order or supreme lodge, without capital stock, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which makes provision for the payment of benefits in accordance with this Article, is hereby declared to be a fraternal benefit society."

The "lodge system" which differentiates a fraternal benefit society from a commercial enterprise is defined by the code as follows: "A society having a supreme legislative or governing body and subordinate lodges or branches by whatever name known, into which members are elected, initiated or admitted in accordance with its constitution, laws, ritual and rules, which subordinate lodges or branches shall be required by the laws of the society to hold regular meetings of at least once in each month, shall be deemed to be operating on the lodge system."

Although all members of fraternal benefit societies are required by statute to be members of some local lodge of the society, with time the social importance of the local group has sharply declined. Modern developments in communication and travel have changed social priorities. Many societies now believe their altruistic and educational activities, as well as their insurance coverage, to be more important than the ritualistic ceremonies that formerly given such great significance.

Under the Uniform Fraternal Code, fraternal benefit societies are required to have a representative form of government, with delegates elected by members and a supreme legislative or governing body to meet at least as often as once in four years. A board of directors has the responsibility for managing the affairs of the group in the period between these meetings.

Members, officers, representatives, or delegates are not to vote by proxy. This indicates a more personal type of organization than that of private insurance firms.

**Not for Profit**

Fraternal societies are required to be non-profit organizations. Under the code definition, a fraternal society is "without capital stock, formed, organized and carried on solely for the benefit of its members, and of their beneficiaries and not for profit." This requirement also applies to mutual life insurance companies.

The membership of the fraternal organization is entitled to any surplus generated from its operation. Such a surplus usually is distributed to members as a refund in much the same way as dividends from mutual life operations are distributed to policy holders.

**Open-Contract Provision**

The most significant difference between fraternal insurance and private company insurance is the "open-contract" provision of fraternal contracts as opposed to the "closed-contract" provision of company contracts.

The companies specify in their insurance policy forms that the policy, together with the application for insurance including declaration of insurability signed by the applicant, constitutes the entire contract.

Laws governing fraternal societies, on the other hand, require that the contract consist not only of the certificate of insurance and the application for membership, including declaration of insurability made by the applicant, but also that the charter or articles of incorporation, the constitution and bylaws of the society and all their amendments constitute the contract.

Also, the fraternal laws require the society's constitution or bylaws to contain a provision that, if the society's reserves should become impaired by loss of assets, excessive mortality or any other cause, members may be required by the governing body of the society to make an extra payment to restore solvency. If a member does not make this extra payment it will remain as a lien against the reserve of his certificate.

Private company insurers have claimed the open contract is an indefinite agreement making a fraternal benefit society member vulnerable to rate increases. Fraternal groups have replied that they would not levy such assessments except under conditions which in all probability would result in receivership for a commercial company.

In such circumstances a commercial company would be required by the state to reorganize through reinsurance, merger, or bankruptcy. A fraternal group faced with such a problem would restore solvency through a policy lien approved by members and authorized by the insurance commissioner of the state.

The lien in no case would exceed the cash value contained in the policy. If a member should fail to pay his

pro rata share of the reserve impairment, the lien would stand until the impairment had been remedied and would then be removed. This procedure would avoid costs of reorganization.

**Tax Exemption**
Another way in which fraternal benefit societies differ from companies is that the fraternals are exempt from federal income taxes. They are also exempt from state, local, and municipal taxes except for taxes and special assessments on real estate and office equipment.

This exemption is similar in philosophy to the nontaxation of churches, charitable institutions, and mutual savings banks. Fraternal groups justify the exemption by stating that their charitable expenditures, such as those for hospitals, sanitariums, homes for the aged, juvenile activities, heart disease and cancer victims, total more than taxes they would be required to pay. Most states do not have minimum standards for such fraternal expenditures.

**Marketing Plans**
Large fraternal organizations now have field organizations similar to those of private company insurers, in contrast to customs when the first fraternals were organized.

New members then were obtained through the lodge. In each lodge a deputy, sometimes called an organizer or field worker, had the job of obtaining applicants to start new lodges wherever possible. Usually these field men were paid a flat sum per member obtained. There was also encouragement for members to solicit new members.

Today the marketing plans of fraternals have grown to resemble that of their company counterparts. Many have a vice president or other officer in charge of sales. He oversees a field force of full-time agents and extensive training programs. Fraternal agents are now given membership privileges in many local associations of the National Association of Life Underwriters. Licensing is required for all full-time fraternal agents under the Uniform Code.

**Reserve Funds**
Separate reserve funds maintained by fraternals differ from those of private companies. Originally, level assessment societies maintained separate funds for expenses, for mortality, and for benevolent projects. Less than half the states however, now require maintenance of separate funds by fraternal societies. The Uniform Code, Section 31, allows the maintenance of either a single fund or a multiple arrangement if desired, reading in part as follows

"A society may create, maintain, invest, disburse, and apply any special fund or funds necessary to carry out any purpose permitted by the law of such society."

"Every society, the admitted assets of which are less than the sum of its accrued liabilities and reserves under all of its certificates when valued according to standards required for certificates issued after one year from the effective date of this Article, shall, in every provision of the laws of the society for payments by members of the society, in whatever form made, distinctly state the purpose of the same and the proportion thereof which may be used for expenses, and no part of the money collected for mortuary or disability purposes or the net accretions thereto shall be used for expenses."

**Certificate Provisions**
Definition of the rights, benefits, conditions, and privileges accruing to parties to a fraternal contract is by the certificate itself, the bylaws and constitution of the society, statutes of the states which apply to fraternal societies, and by common law where none of these apply. These diverse influences working on the fraternal insurance certificate explain any lack of uniformity within fraternal contract provisions.

Being family-oriented, the fraternal society historically restricted the classes of people which could be named beneficiaries in the insurance certificate. Contract provisions today provide more liberal beneficiary designations. The member can change beneficiaries at will provided the substitute beneficiary falls into the approved class defined by the society or by statute.

The facility of payment clause is a feature found in some fraternal certificates. This clause is common to

industrial insurance contracts but not to ordinary life contracts. It defines instances in which the fraternal society or insurance company may disburse benefits to others than the named beneficiaries or where there is no named beneficiary.

**Payment Options**
Fraternal insurance contracts offer settlement options to beneficiaries, but generally not to as great an extent as company contracts. The difference is believed to be due to the smaller size of the average fraternal contract as compared to the average company contract. Most fraternal settlements are made in lump-sum payments, although the use of income options is increasing.

Changing by fraternal societies from an assessment to a legal reserve basis necessarily was accompanied by reserve accumulation in which equities were developed by the insured. Nonforfeiture values offered by fraternals are the same as those offered by private insurers except as to which option will be used in the event of a lapse of premium payment without an election by the insured.

In the event of a lapse, private insurers usually utilize extended term or automatic premium loan. There seems, however, to be no generally used option among fraternal societies. The Uniform Code in Section 16 states that "as to certificates issued on or after the effective date of the Article, a society shall grant at least one paid-up nonforfeiture benefit," and provides for nonforfeiture values.

Similar in the fraternal insurance certificate and the private contract are provisions for a grace period and an incontestable clause. The grace period, like that provided in commercial contracts, is usually 30 days. The incontestable clause, although it varies with societies, is included in all fraternal certificates.

**Disability Coverage**
An important contribution to the life insurance industry of the country was made by fraternal societies in pioneering the development of total and permanent disability coverage attached to life insurance contracts. From the disability experience of certain fraternal societies, the first disability tables used in this country were developed.

**Continued Significance**
Changes in the social and cultural environment have caused the lodge system and its original sphere of activity at the local level to decline in importance. Fraternal leaders, however, maintain that the local lodge continues to be an integral part of the system. Differences between the insurance operations of good fraternal benefit societies and good private companies have become less significant.

Whether the difference between the open and closed contract is significant would depend on the financial strength of the organizations concerned. Otherwise the contrast between the two types of organization is now chiefly in the noninsurance activities of the fraternal benefit societies--the lodge system, representative government, and charitable or other service programs. The financially sound fraternal benefit societies remain a separate and significant part of the total system of insurance protection in America.

**Overall Picture**

The insurance industry, whether through mutuals, stock companies, or fraternals, contributes to a healthy national economy through carefully selected investments. In this way it also contributes to individual financial security, and the security of individuals is basic to the national economy in turn.

Life insurance investments in residential mortgage loans have made it possible for millions of American families to improve their standards of living by purchasing homes. Insurers' investments in business and industry provide economic growth which increases both the national product and employment.

Life insurance investments are designed to meet long- term future obligations to policy holders, and for this reason play a most important part in the national economy.

**Research Programs for the Future**
Long-term programs of basic research are supported by insurance related organizations, including the

Institute of Life Insurance. Part of the reason is that the industry recognizes the need to learn more about the changing socioeconomic climate in which personal insurance operates. Many people in the life insurance business feel that an increase in the knowledge of human behavior will benefit the insurance business and the people and society it serves as well.
Studies of the Institute of Life Insurance program are carried out independently by social scientists. The Institute selects studies that will receive its support with the assistance of advisory authorities in several branches of the behavioral sciences. The program centers on the family, the impact on it of social changes, and contributions of individual family members' attitudes to the behavior of the family as a unit. These programs are designed to aid the insurance business in responding adequately to changing needs.

**Insurance Business Organizations**
In the insurance business and related fields, organizations have been an important source of strength to practitioners. They have served as a way to exchange ideas and information in order to solve common problems, and have stimulated competition in the industry which has served the interest of the public.

Some of the more important organizations include the American Life Convention, American Society of Chartered Life Underwriters, Health Insurance Association of America, Health Insurance Council, Health Insurance Institute, Home Office Life Underwriters Association, Institute of Life Insurance, International Association of Health Underwriters, Life Insurance Management Association, Life Insurance Association of America, Life Insurance Medical Research Fund, Life Office Management Association, Life Underwriter Training Council, Million Dollar Round Table, National Association of Underwriters, and Society of Actuaries.

There are other groups which make contributions to the effectiveness and public service of the life and health insurance business, including organizations of company specialists in medical, legal, investment, public relations, accounting, and statistical fields.

For those with a scientific interest in insurance, the American Risk and Insurance Association is devoted to advancing the science of risk and insurance through education, research, literature, and communications. State supervisory officials in insurance through the National Association of Insurance Commissioners have an exchange medium for ideas and trends. This group aims for as much standardization as possible of insurance regulations by states.

These organizations together have made an important contribution to the advancement of insurance in the interest of the policy holders. They have intensified competition among individual companies while also providing the framework for extensive cooperation in research and methods.

**Contributions to the Economy**
Both the size of the companies' financial operations and the unique way in which its investment funds are channeled give insurance its special importance in the nation's economy.

Insurance companies both as investors and employers make vital contributions to the health and stability of the country as a whole. It has been estimated that one out of eight individuals in the work force today is employed in an insurance-related activity.

In their role as insurers, providing money when the family most needs it, life and health insurance companies make a direct contribution to the health and stability of the basic unit of society. The total of benefit payments nationally is impressive, but the individual or family share of this total is more than impressive--it is a lifeline. Cash value life insurance is one of the most important long-term savings arrangements, providing billions of dollars of financial resources for individual families while producing massive investment funds for the economy as a whole.

**International Developments**
A new frontier for expansion of the U.S. insurance industry is developing internationally. Major global economic processes being taken into account by forward-looking insurance executives in this country are the economic integration of Europe, the "marketization" of the command economy in China, and the acceptance of private insurance in Russia and former Communist Bloc countries.

Advances in telecommunications and transportation have made it possible to consider opening overseas

offices on a scale which once would have seemed impossible. The prospect offers American insurers the combined opportunity of providing greater financial security to millions of clients around the globe while simultaneously contributing to a more favorable balance of payments in this country's international trade.

**Importance of Background**

Knowledge about the general organization of the insurance industry as well as about the history of its development will help give the professional person dealing with insurance an understanding of how uniquely important it is to individuals and society. Knowing the importance of the industry and of the risks associated with it makes one aware of the pattern of income needs that must be underwritten if people are to lead lives of financial security.

The scientific principles underlying the operations of an insurance company explain the continuing overall soundness and solvency of insurance as a financial institution.

**RECAP**

Risk coverage began in the early days of civilization with people who achieved an understanding of probability theory. Money lenders found that they could collect extra premiums on loans to protect merchants against shipping losses and in that way make an extra profit. From marine insurance against accidental loss of goods there evolved policies protecting against piracy and thus eventually against loss of life.

Life insurance was hardly known in colonial America because the rural population was mostly self-sufficient. After the coming of the Industrial Revolution split production and consumption apart, mass production in city factories brought workers in from the farms. In the cash economy of the growing cities, those who wanted security for their families began to turn to insurance to provide it.

During the nineteenth century, the amount of insurance in force grew rapidly. Overexpansion led to disaster for mismanaged insurance companies during the depression of the 1870s, but the stronger ones survived. Mutual companies, the earliest established in this country, were joined by stock companies run on a businesslike basis.

State regulation requiring adequate reserves for insurance suppliers began in Massachusetts, largely through the efforts of Elizur Wright. He developed a valid actuarial system and lobbied for state regulation to back it up. Other states adopted regulatory laws. Then new expansion and new abuses brought on the Armstrong Committee investigation, headed by Charles Evans Hughes, in New York in 1906. Most states adopted insurance regulations after that and, with renewed public confidence, expansion of the industry resumed. A record $20 billion in new insurance was written in 1929, and in that year insurance in force passed $100 billion. Then came the crash of 1929.

The insurance business was not as hard hit as some others were by the Depression, even though for the first time in a generation the total of insurance in force decreased. Industry cooperation, reinsurance, and state regulations protected policy holders from major losses.

Awareness of the need for security made insurance more widely appreciated. The massive government coverage launched with Social Security did not interfere with the growth of private insurance. Developments such as low- cost group insurance, disability riders; double indemnity payments, credit life insurance, and annuities increased the popularity of insurance through the years.

Professional training courses for those engaged in the insurance profession have led to increased public confidence and industry standing. By the 1980s the total of life insurance in force in this country had reached approximately three trillion dollars, more than 25 times the 1940 level.

Types of companies operating in the insurance field today include mutuals, stock companies, and fraternals. The mutual company is owned by its policy holders and operated for their benefit. It issues participating policies which pay annual dividends to policy holders.

While mutual companies in general are the older and larger organizations, stock companies are more

numerous. Stockholders, who expect a return on their investment, provide their financing. Stock companies usually issue nonparticipating policies at lower premiums than those of the mutual companies. In the case of the mutuals, however, annual dividends to policy holders reduce the policy cost from the original premium amount.

Fraternal organizations, important in the country's early social development, attracted farm and labor segments of the population who distrusted commercial insurers. They could not afford to pay for ordinary life policies and did not understand reserve accumulations and level premiums as used by the large insurance companies. The failure of some insurance firms during the depression of the 1870s also made them distrustful.

As the average age of lodge members increased, however, it became more difficult to attract younger members and maintain a constant age distribution. Younger members realized that they were paying too much proportionately and began to drop out. By the turn of the century the fraternals found it necessary to join forces and develop a sound actuarial basis for operation. In cooperation with the National Association of Insurance Commissioners, uniform state regulation of fraternals was set up.

Fraternals now operate under special provisions and are exempt from federal income taxes as well as most state and local taxes. Marketing of policies by fraternals, although confined to membership, resembles that of other insurance organizations.

The insurance industry as a whole makes a unique contribution to both individual security and the soundness of the nation's economy. It achieves this as a mechanism for channeling personal savings into major industrial development throughout the country.
Advances in telecommunications and transportation also are opening up new frontiers for international expansion of the U.S. insurance industry in new markets with prospects for a major impact on the global economy.

# CHAPTER TWO Basic Life and Health Insurance

For most individuals and families the earning ability of the provider or providers is the most important and often the only significant asset of the family.

Life insurance and health insurance are both essentially income protection products. Both belong in the category of human life value insurance, as distinct from property value insurance. Both aim to protect against the absence of current earned income, either permanently or temporarily.

Health insurance originally was a "casualty" line. With the recognition of the complementary nature of life and health insurance, however, a large portion of the health insurance business is now underwritten by life insurers or their affiliates.

**The Human Life Value Concept**

The altruistic aspects of life insurance were commonly stressed in the early years of the industry's development. The profit motive of life insurance to the premium payor was made so little of as to give the idea that the head of the family had no prospect of benefiting personally.

Life insurance until the late 1920s was generally regarded as purely "death" insurance, with no explanation of what it really was that died. Buying insurance was largely a matter of selecting a contract of $2,000, $5,000, $10,000, $15,000, or $20,000 without any very thoughtful valuation of the insured life. The personal estate, meaning property, was given much consideration, while the person in that personal estate was overlooked.

Little stress was laid on the "living values" of cash value life insurance, such as freedom of mind to venture, thrift, sound and profitable investment, improved credit, greater vocational security, and wise management of the human life value. The insured picked some policy figure without any attempt at thoughtful appraisal of the money value of his life to his dependents.

The general attitude was that life insurance contracts were certain to meet their promises because of their actuarial foundation. Thus there could be no cheating of the policy holder no matter what type of contract he purchased.

In this thinking the buyer always received his money's worth. The insurance agent's greatest achievement for good was to sell the largest volume of offered contracts possible. Naturally this aim did not involve evaluation and analysis of the buyer's economic circumstances and real needs. In general a true professional attitude was ignored.

The human life value concept was proposed in 1924 as a philosophical framework for the analysis of basic economic risks facing individuals. Under this concept, now widely accepted in life insurance circles, there is a material change in previous views.

It had been assumed that life insurance was essentially a physical death proposition which could not offer a profit motive to the payer of premiums, and therefore all that was really necessary was sheer volume selling without adequate knowledge and professional attitude.

Benjamin Franklin once observed it was a strange thing that men "should be careful to insure their houses, their ships, their merchandise, and yet neglect to insure their lives, surely the most important of all to their families, and more subject to loss." The logical development of the human life value concept, however, was not recognized until the 20th century.

More than just a statement that human life has an economic value; the concept involves these six important considerations for life insurance service:

① The human life value, expressed with a dollar valuation, should be carefully appraised and capitalized for insurance purposes. This may be defined as the capitalized value of that part of the current earning power

of the individual which is devoted to the support of family dependents, and sometimes the protection of business associates.

An illustration of one simple method of appraising the economic value of a human life might be as follows: The gross annual income of a man aged 35 from his personal efforts is $36,000. After income tax he has a net income of $29,000. He uses $9,000 for his direct self-maintenance, leaving $20,000 of his earnings for the support of his wife and children.

He plans to retire at age 65, so he can expect 30 more earning years. Assuming that his earnings, taxes, and distribution of income will remain approximately the same over those years, the economic value of his life can be calculated by discounting at a reasonable rate of interest, say six per cent, the income flow of $20,000 a year for 30 years.

At six per cent interest, $1 per year for 30 years is worth $13.765, and this amount times $20,000 rounds off at $275,296, his life's economic worth to his family.

The human life value concept is being expressed as the present value of an income stream. Look at the example another way. Even without taking inflation into account, a dollar today is worth more than the assurance of receiving a dollar a year from now. It is preferable to receive $1,000 now rather than the promise of $1,000 at some distant future date. This preference rests on the time value of money.

Generally, the term interest is used to describe the price charged for using money over time. When we make payments for the time value of money (an automobile payment), we incur interest expense. When we receive payments for the time value of money (a savings account), we earn interest revenue. The accumulated amount of a single sum invested at compound interest can be computed period by period using a series of multiplications. We may also, through a series of computations, arrive at a discounted present value of a principal sum to be paid or received at a fixed future date. Used here is the concept of annuity payments, involving periodic payments or *rents* with interest over a fixed period of time.

With our 35-year old male above, the future value of his income can be computed. "Payment" in the computation represents the component of the 35-year old male's income used to support his family.

Payment = $20,000
Interest = 6%
Number of periods = 30

$$fv = P\frac{(1+i)^n - 1}{i}$$

-Or-

$$fv = 20{,}000\frac{(1+.06)^{30} - 1}{.06}$$

=20,000 (79.058187)
= $1,581,163, the future value of his current income.

Now find a present value of this future cumulative worth, using the same assumptions;

$$pv = fv\left(\frac{1}{(1+i)^n}\right) or \qquad pv = \frac{fv}{(1+i)^n}$$

-So that-

=1,581,163÷5.7434912

= $275,296 again, his life's current economic worth to his family.

Many variables obviously could enter into such an appraisal of human life value. This illustration only shows the logical basis for appraising and capitalizing the values inherent in a human life.

A rough appraisal of the total human life values in the United States under this system would give an

amount of about five times the total of property values in the country. As the population increases and ages, this total of capitalized life values will continue to increase. It needs to be maintained not only for dependents in case of premature death of the breadwinner, but also for protection of the children against the burden of financial support of parents after "retirement death."

Adding to human life values in the United States would be the money value invested by parents in young people's education, human life values for strictly business purposes, for credit purposes, and for bequest purposes.

Also human life values contribute heavily to income from interest, corporate profits, partnerships, and sole proprietorships. Human life values for all purposes easily would amount to ten times the property values in the nation.

② The human life value should be recognized as the creator of substantially all property values. The human life value is the cause and property values are the effect. Human life value motivates otherwise inanimate property into a productive force. Probably half of the total national income from interest, corporate profits, and sole proprietorships is attributable to the human life value motivation of the property involved.

③ The family should be regarded as a business partnership from an economic point of view. Of course there are other points of view, including religious, social, and legal, but a sensible and realistic attitude includes viewing the family as an economic institution.

Throughout human history the family has been regarded as man's first and most important business enterprise. Thus it needs to be organized first, then managed, and to have its economic values finally liquidated in the same sensible way that other business enterprises are organized, operated, and liquidated.

The business or professional vocation of the head of the family, although very important, should be regarded as a secondary business to be pursued in the interest of giving the greatest advantages to the first enterprise, the family business. Also the family head needs to recognize the creative functions of life insurance for personal advancement as an income producer. This will allow the family head to support the first and most important business, the family business.

Life insurance has long been used to preserve a family's economic security after the death of the family's income producer. From the family standpoint, life insurance is a necessary business proposition that may be expected of every person with dependents as a matter of course, just like any other necessary business transaction. The family should be established and run on a sound business basis. It should be protected against needless bankruptcy. The death or disability of the head of this business should not involve its impairment or dissolution any more than the death of the head of a bank, railroad, or store.

④ The human life value should be regarded as the principal link between present and future generations with regard to protective benefits from life and health insurance. When successive generations are considered, property values tend to be fleeting. The human life value, on the other hand, deals with proper care and education of the children in case of the family head's premature death or disability, or in case hopes for personal success are not fulfilled, for protection of the children against the burden of support of their parents after retirement.

⑤ The same fundamental principles of appraisal, indemnity, conservation of values, accounting, capitalization, accumulation of surplus, sound investment, credit, last will and testament, and liquidation tradition all applied to property values should be applied to human life values. Applying these principles to the larger and more significant human life values is possible through life and health insurance.

These arrangements make it possible to apply to our life value, our current earning capacity for others, all the basic economic principles of organization, management, and liquidation which just as a matter of common sense have been applied to property value possessions through the years.

⑥ Human life value is subject to loss of earning power through four serious hazards: premature death, or "casket death," temporary disability, including medical and surgical expenses, total and permanent disability, or the "living death," and compulsory retirement, or the "retirement death." A sense of obligation on the part

of the family head takes into consideration the rights of dependents and their claims in the family business partnership with respect to these four hazards.

There was considerable opposition to the human life value concept at first on the basis that the economic value was in conflict with "sentimental value" or "spiritual value." The idea of attaching a dollar value to human life was regarded in some quarters as too awful to contemplate. Human life was classified in a category of values very different from the economic concept of value, for insurance purposes as well as otherwise. Yet the religious and moral obligations of family heads to use dollar protection for dependent families are plain. The sentimental and spiritual values are undeniable, but so are mortality and morbidity tables attesting with precision to unfortunate economic happenings in American family life.

Recent court verdicts running into hundreds of thousands and even millions in negligence cases involving total and permanent disability emphasize the recognition of human life values. From this viewpoint it is strange to consider that many heads of families protect their dependents with only a few years' earning power. A firm economic foundation for family welfare is a tremendous token of love.

**Life Value and Earning Capacity**
A young bridegroom may say "With all my worldly goods I thee endow," when at the beginning of his working life his current income may be small. In this case "worldly goods" means potential future earning capacity. It should be recognized realistically and capitalized for the maximum amount obtainable for his human life value through life and health insurance.

The potential estate through life insurance is at such a time more important than the purchase of a home. The dependable consummation of the estate in cash for family purposes is the all-important thing if death or disability occurs.

As the family standard of living improves with the increase of regular income over time, it is essential for the head of the family to increase life and health protection accordingly. Since most family heads now survive to retirement age, it is also essential for life insurance to provide substantial retirement values for liquidation purposes on a life annuity basis for husband and wife so they will not have to depend on their children for financial support.

**Vocational Group Variation** Vocational groups which make up the economic life of the country are a determining factor in analyzing the business worth of the human life. In the group of wage and salary earners, there is almost always a nearly total loss of income to family dependents in the event of death or disability of the family head. In most cases the supreme objective for protection against loss of income to the family should be the protection of the human life value asset of the family breadwinner.

In vocations of the professional and other expert types, where the chief asset is the goodwill of clients, the situation is similar to that of wage and salary earners. Life value from a current income point of view is usually much greater than accumulated property values. Although there is some property, regular income from the profession is largely associated with the continued patronage of clients, which in turn is dependent on the continued effective working life of the practitioner who created these personal associations.

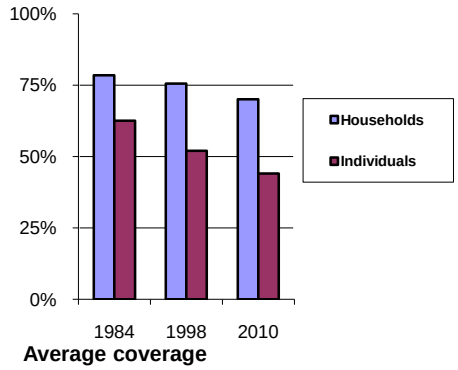
In vocations concerned chiefly with the fulfillment of long-running contracts, the life value of the contractor nearly always greatly exceeds the money value of the equipment in use for his ventures.

In the agricultural group considerable property is involved, but current income is attributable primarily to personal ability and hard work. The difference in ability makes the difference in the life value involved.

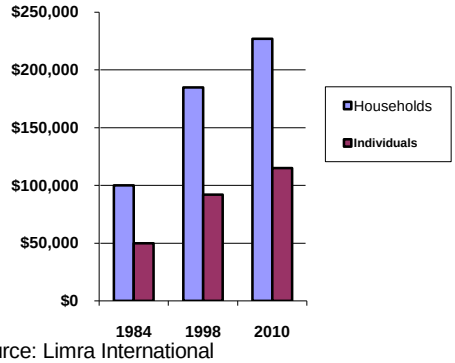
In the group of those involved in manufacturing, mercantile, and other industrial activities, there is much property obviously involved. But even in such cases, a careful appraisal of life values and property values will show that most often, after deducting the amount of borrowed funds, the property values actually owned outright are greatly exceeded by the monetary worth of the directing life values.

**U.S. Life-Insurance Ownership**

**Percentage Owning Any Life Insurance**




**Average coverage**




Source: Limra International

**Role of Life Insurance**

Insurance provides protection against all forms of economic death, including premature or "casket" death, total and permanent disability or "living death," and compulsory "retirement death."

The first of these, physical death during the earning period of life, is always an overwhelming concern to families. Life insurance is necessary to guarantee an adequate estate for dependents if the breadwinner does not live long enough to accumulate the estate through earnings and investments.

The total of life insurance in force in this country, although in the trillions of dollars, represents on the average only a few years of protection for individual families. Life insurance premiums annually amount to only a very small percentage of disposable personal income. It has been estimated that the average amount of life insurance per family represents only about 10 per cent of what would be needed to meet a full obligation to a person's first and most important business, the family.

Present economic desires in general come first with the average family, and family requirements for the future come last. For sound economic welfare, the second part of the family budget needs to be emphasized and the percentage of disposable family income devoted to life insurance protection needs to be increased just to keep up with inflation. The sense of obligation in economic, moral, and religious terms underlying the private enterprise system is scarcely served by the present division of family budgets.

The most dreaded of all forms of economic death is the "living death" of total and permanent disability. The victim cannot earn current income and the family spends its nest egg not only for current living costs but also for maintenance and medical expenses. But the degree of insurance protection against this unfortunate fate is even smaller than that against premature death. The need for increased coverage in this area is vital to the health of the economy.

From an economic standpoint, compulsory "retirement death" has become more important than premature physical death. With the increasing life span in this country, the odds are that a breadwinner will live to retirement age. In the great majority of cases both husband and wife are survivors at age 65. Also in the majority are the wives who will outlive their husbands.

Maintaining the appraised value of human life for life insurance purposes is desirable so the value may then be liquidated for old-age support in the form of a dependable annuity income for both husband and wife. This income should be available to the end of the life of the last survivor of the two in order to protect the children and their families against the burden of parental financial support. The joint-and-last-survivor annuity arrangement is often desirable since both spouses probably will be alive at 65 or 70.

Annuities and pensions are generally regarded as protection against the "retirement death." For the "living death," total and permanent disability insurance also should be regarded as an annuity. In case of "casket death," all settlement options except leaving life insurance proceeds at interest are annuity options of various kinds.

**Principles of Value Treatment in Life Insurance**
The fundamental principles of organization, management, and liquidation commonly applied to property values can be applied to the organization, management, and liquidation of human life values through the medium of life insurance.

**Appraisal**
Families need to use a budget plan to determine the proportion of total family income devoted to the support of dependents after the deduction of the portion applied to the support of the family head. Then the capitalized amount for the benefit of survivors in the event of the death of the family head can be determined.

At that point it is important to plan what type of insurance contract is to be used. Total family needs should be considered by the underwriter rather than only one or two immediate needs at the time of solicitation. Should the original policy be term insurance because the insured represents essentially a potential estate situation, or a higher premium contract such as straight life or limited-payment insurance, or a long-term endowment policy maturing at the retirement age of 65 or 70?

It has been estimated that only about 10 per cent of human life values are covered with life insurance, as opposed to property values, which are about 80 per cent covered with fire insurance and approximately 100 per cent with marine insurance.

**Capitalization:** Through cash value life insurance (straight life to long-term endowment); capitalization of life values is entirely practical. Such life insurance constitutes a "callable sinking fund bond" issued against exhaustible human life values, just as such bonds have been issued against exhaustible property values for many years.

The bond has two complementary sides, a "sinking fund" side and a "callable" side. The sinking fund side starts small at the beginning and keeps on increasing until it accumulates to the face of the contract at age 65. The callable side, applicable in case the insured dies prematurely, starts at nearly the face of the contract and keeps on decreasing, in the form of decreasing term insurance, until it reaches zero at the same time the sinking fund has reached 100 per cent of the face of the contract.

The two sides move in opposite directions at exactly the same rate, and at any time during the policy period the two sides together equal the face of the contract.

**Accounting Principles**
The sinking fund side of the life insurance bond represents the principles of accumulation of surplus and sound investment on the installment plan. The callable side can be made to represent the accounting principle of "obsolescence" of the human life value in the event of total and permanent disability. The sinking fund is created scientifically to meet future unknown contingencies such as unemployment and serious illness. The depreciation fund and liquidation recognize the exhaustible nature of the human life value at a fairly average age such as 65 or 70. A fund is methodically accumulated to equal the depreciation of life value, so it will be available for liquidation on a life annuity basis.

**Importance of Background**
Knowledge about the general organization of the insurance industry as well as about the history of its

development will help to provide an understanding of how important insurance is to individuals and society. Knowing the importance of income and of the risks associated with it makes one aware of the pattern of income needs that must be underwritten if people are to lead lives of financial security. The scientific principles underlying the operations of an insurance company explain soundness and continued solvency of insurance as a financial institution.

In some industries, prices are based largely on competition. In life insurance, rates are based on scientific principles. To compute policy rates low enough to encourage the spread of the benefits of life insurance and yet high enough to give margins of safety for the companies providing it is a science resting on hundreds of years of study. Records have been kept, monitored, and updated over those years to establish workable rates.

Although the public as a whole may know more about the principles of life insurance than in the past through standard business courses in high school and college, there still can easily be misunderstanding or ignorance of technical facts on the part of a prospective policy holder. A well informed industry representative can clear up such questions better with confidence resulting from sound background information about the way insurance developed and how the business is structured.

Three fundamental factors affect premium rates. They are mortality, interest, and operating costs. Methods of computing premiums, cash values, reserves, and other factors enter into rate-making.

**Male/Female Rates**

Women on the average live longer than men. This is the reason such things as mortality tables, premium rates, and life income settlement options traditionally have been based on the less favorable male mortality or life expectancy. Then adjustments are made in the figures for females to reflect their more favorable mortality rates. In the late 1980's some companies adopted unisex life insurance rates and values. Unisex rating has since been rejected in many jurisdictions. Using the standard mortality table in studying rate construction, it is well to bear in mind that the figures given are for males, but the same principles with more favorable mortality rates apply for females or a combination of both men and women.

**Life Expectancy for Applicants at Different Ages**

There is a nearby table that shows the life expectancy for individuals at different ages. The chart and data are provided by the California Department of Health Services, Center for Health Statistics, Office of Health Information and Research.

Note that half of the people in any age cohort will live longer than the mean expected age for that cohort while half will survive a shorter time span.

**Mortality as a Rate Element**

An important assumption in life insurance rate-making is that people will die at the same rate in the future as they have in the past. The mortality tables show the past death rate, and it is assumed that the same rate will hold good in the future. If this assumption proves not to be correct, new mortality tables have to be produced.

For a simple example of rate-making, assume that 1,000 men, each 35 years old, form a group to share the risk of death. They elect officers to administer the plan without pay. The money collected to meet claims is not invested but held in cash.

If death of a member of the group occurs within the term of one year, the claim is paid, but if death does not occur, the insurance expires at the end of the year. It then must be renewed and the proper premium paid for the next year, based on the increased mortality rate for one more year of age.

In the real world, premiums collected by life insurance companies are not stored in cash in a vault until needed. The companies' assets instead are invested in various ways and the interest earned becomes an important factor in computing the rate to be paid for insurance coverage. The first assumption a company must make is that of a death rate. Then comes the study of the effect of interest earned on investments.

| **Abridged Life Table** | **CALIFORNIA, 2004 FOR TOTAL POPULATION** | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Age Interval** | **Proportion Dying** | | | **Of 100,000 Born Alive** | | **Stationary Population** | | **Average Remaining Lifetime** |
| | Uncorrected | Correction Term | Corrected | | | | | |
| Period of Life Between Two Exact Ages | Average Annual Death Rate | Fraction of Last Age Interval Lived | Proportion Dying During Age Interval | Number Living at Beginning of Age Interval | Number Dying During Age Interval | In the Age Interval | In this and All Subsequent Age Intervals | Average Remaining Years of Life |
| 0-1 | — | 0.17347 | 0.00516 | 100,000 | 516 | 99,573 | 8,020,023 | 80.20 |
| 1-5 | 0.00025 | 0.40036 | 0.00099 | 99,484 | 99 | 397,699 | 7,920,450 | 79.62 |
| 5-10 | 0.00013 | 0.50429 | 0.00064 | 99,385 | 63 | 496,769 | 7,522,751 | 75.69 |
| 10-15 | 0.00015 | 0.58096 | 0.00075 | 99,322 | 75 | 496,453 | 7,025,982 | 70.74 |
| 15-20 | 0.00058 | 0.59917 | 0.00287 | 99,247 | 285 | 495,664 | 6,529,530 | 65.79 |
| 20-25 | 0.00083 | 0.49584 | 0.00416 | 98,962 | 412 | 493,772 | 6,033,865 | 60.97 |
| 25-30 | 0.00078 | 0.49343 | 0.00388 | 98,550 | 382 | 491,782 | 5,540,093 | 56.22 |
| 30-35 | 0.00087 | 0.52497 | 0.00436 | 98,168 | 428 | 489,823 | 5,048,311 | 51.43 |
| 35-40 | 0.00120 | 0.52475 | 0.00600 | 97,740 | 586 | 487,307 | 4,558,489 | 46.64 |
| 40-45 | 0.00191 | 0.53592 | 0.00951 | 97,154 | 924 | 483,625 | 4,071,182 | 41.90 |
| 45-50 | 0.00304 | 0.52885 | 0.01510 | 96,230 | 1,453 | 477,725 | 3,587,557 | 37.28 |
| 50-55 | 0.00450 | 0.52113 | 0.02227 | 94,777 | 2,111 | 468,829 | 3,109,832 | 32.81 |
| 55-60 | 0.00636 | 0.52590 | 0.03135 | 92,666 | 2,905 | 456,443 | 2,641,003 | 28.50 |
| 60-65 | 0.00947 | 0.52373 | 0.04631 | 89,761 | 4,157 | 438,906 | 2,184,560 | 24.34 |
| 65-70 | 0.01430 | 0.52682 | 0.06915 | 85,604 | 5,919 | 414,016 | 1,745,654 | 20.39 |
| 70-75 | 0.02274 | 0.52421 | 0.10787 | 79,685 | 8,596 | 377,974 | 1,331,638 | 16.71 |
| 75-80 | 0.03610 | 0.52024 | 0.16611 | 71,0896 | 11,809 | 327,118 | 953,664 | 13.42 |
| 80-85 | 0.05928 | 0.51837 | 0.25939 | 59,280 | 15,377 | 259,372 | 626,546 | 10.57 |
| 85 + | 0.11957 | fin | 1.00000 | 43,903 | 43,903 | 367,174 | 367,174 | 8.36 |

Sources: State of California, Department of Finance, 2004 Population: 2000-2050 Population Projections with Age and Sex Detail, May 2004. State of California, Department of Health Services, Birth and Death Records

**Measuring Risk**

Life insurance has as its fundamental principle sharing the risk of death by members of a group. The financial loss caused by death can be distributed among the members of a group at a small cost to each. Group sharing cannot eliminate death, but it can offset death's disastrous financial consequences.

To determine the rate that each member of an insuring group must pay, it is necessary to know how many members will die within a given period of time. There is no way to know how much money to collect until it is known how much money must be paid out to survivors of members who will die within a year. The cost of mortality depends on the rate of mortality. Thus a group cannot share a loss until the extent of the loss is known.

The problem of finding a way to measure the "rate of death" faced the founders of early life insurance companies. To solve it they studied census reports, church records of christening and funerals, and dates of births and deaths from tombstones in parish burying grounds. Enough statistics slowly were compiled to determine how many persons could be expected to die within a given year and at a given age.

**Mortality Tables**

Rates of death compiled statistically for all ages are known as mortality tables. The data are based on mortality figures of very large groups of people over long periods of time, and therefore life insurance companies can rely on them with confidence. The mortality table shows the average mortality experience for all people of a measurable group over many years. It is revised at intervals as time goes on and more statistics become available

The problem of measuring the risk of death is solved from the mortality tables. Only when the risk is measured is it possible for the rate to be determined.

No one can ever determine which individual in the group will die within a given year, but it is not necessary to know who will die in order to determine a rate. Only the number who will die needs to be known in order to make a rate determination. Then the amount of money that must be available each year to meet the death claims can be determined.

**Interest as a Rate Element**

In the example of the company in which 1,000 men are to pay identical premiums for $1,000 one-year term policies, if the group were to decide to invest the money collected for premiums instead of keeping it in cash

two assumptions would be made. These are standard assumptions for all life insurance companies.

First, it is assumed that all premiums are paid at the beginning of the year and all death claims are paid at the end of the year. Second, it is assumed that the company will earn a specified net return on money invested.

Neither of these assumptions, obviously, is exactly true, but companies use them in order to simplify premium computations. Actually premium payments are scattered throughout the year, and all policy holders do not wait until the end of the year to die. But for computation purposes it is assumed that each premium earns one full year's interest.

Also, there may be a fairly wide range of interest rates on various types of investments made by the company. A conservative average is used as the assumed rate of return used in premium calculations. The interest rate assumptions used by life insurance companies are purposely low to allow a margin of safety. They may vary from two per cent to four per cent or higher. Assumed rates also may vary for different types of policies offered by the same company. An insurer's interest rate assumptions directly affect its policy reserves. The higher the rate, the larger the reserves.

For illustration in the following example, an interest rate of two and a half per cent is selected. Each of 1,000 men pays a premium of $2.51, assumed to be on January 1. The total of $2,510 is immediately invested by the treasurer at two and a half per cent interest for a full year.

At the end of the year, before payment of any death claims, the company would have on hand the $2,510 collected in premiums plus two and a half per cent interest on that amount, for a total of $2,572.75. Thus the treasurer knows that instead of collecting $2.51 from each of the 1,000 men, he needs to collect only an amount that will become $2.51 when interest for one year is added to it. Interest of two and a half per cent on $2.45 is six cents, which added to $2.45 makes $2.51. So by collecting $2.45 from each member, or $2,450 from the group, the treasurer will have at the end of the year the $2,510 needed to pay the 2.51 death claims of $1,000 each.

Actually, the nation's life insurance companies hold billions of dollars worth of assets. Interest earnings on these investments not only decrease the cost of life insurance to the policy owner, but also serve as a huge fund for long-term investment in the economy of the country. Life insurance dollars do not lie idle in a vault. They go to work immediately providing public and private financing.

**Expense as a Rate Element**

A third factor enters into computing rates in addition to mortality costs and interest earnings. A life insurance company cannot operate without expense. In order for premium money to be invested promptly and wisely, the company must employ an investment officer. In order to be sure that only people in good health and of sound character are accepted as members of the group, a competent underwriter is needed. To meet the needs of prospects, rates must be determined and a variety of policies devised.

To take the story of life insurance to the public an agency organization must be created. Supplies must be purchased and rent and taxes paid. The expense factor thus becomes a very important phase of rate-making.

Life insurance actually is a social service institution, the medium through which people can organize into groups for risk sharing. The social implications of life insurance are great, and it is a matter of sound public policy that it should be provided at the lowest cost consistent with sound service and safety. Successful insurance companies do everything possible to hold operating expenses to the minimum.

The expense factor is sometimes called "loading" because it is added or "loaded" onto the premium rate determined on the basis of the first two factors, mortality and interest.

**Increasing Rate Problem**

In a final look at the make- believe group of 1,000 men, each 35, who are insured for the term of one year for $1,000 each, it can be seen that the yearly cost of that insurance can be determined by placing a dollar sign before the figure that indicates the death rate per 1,000 for various ages in the mortality table. This

example omits consideration of interest or expense factors.
By placing a dollar sign before each of the figures it can be seen that year after year, the men in the group of 1,000 whom continue living will have to pay an increasing premium. During the early years the increases are slight, but later they become large. Term insurance costing $2.51 at age 35 goes to $5.35 at age 45, and increases to $13.00 at age 55, to $31.75 at age 65, and to $73.37 at age 75.

This kind of increase in premiums over a normal life span would cause financial hardship by requiring higher payments at the time of life when need for life insurance is greatest because of the increasing probability of death. Earnings of the average person usually reach their high point in the middle years, remain stable for a time, and then begin to decline. A plan of calculating premiums that requires large increases at the time when earning power has stabilized or is declining defeats the basic purpose of life insurance, which would call for a "level premium" remaining constant during the entire life of the individual insured.

**Level Premium Construction**
It took creative mathematical minds to find a solution to the problem of drastic increases in premiums for older individuals. Complex mathematics is involved, but an understanding of the basic principles will provide confidence in the structure of premium rates.

In simple terms, the increase in the yearly term rate is leveled over the anticipated lifetime by charging more than is currently necessary in the earlier years and thus creating a fund for the heavier mortality charges of the later years. The level premium is higher than necessary in the earlier policy years and lower in the later policy years. The portion of the earlier premiums that is larger than needed to meet current mortality and expense costs is set aside by the company in a special fund known as the reserve or legal reserve. The reserve is immediately invested because earned interest is assumed when the level of the premium is set.

An example will show how the reserve operates to produce scientific equity. For a group of 93,738 men at age 35, a basic $1,000 policy has a net level annual premium, with figures for the cost of death calculated to the millionth place, of $17.671147. When this figure is collected from 93,738 men, receipts at the start of the year total $1,656,458. At two and one-half per cent interest these receipts produce a total of $1,697,869 at the end of the year.

At this point, 235 death claims for the year are paid for a total of $235,000. Subtracting this figure from the total of receipts plus interest leaves a reserve balance of $1,462,869 at the end of the first year. After that, each year's gain or loss in the column headed "Receipts Plus Interest Minus Claims" column is factored into the previous year's reserve. The sum, plus the year's two and one-half per cent interest earnings, produces the reserve at the beginning of the next year.

The reserve reaches its high point of $36,435,377 at age 65. Then it decreases until at the end of the table there are only sufficient funds remaining, combined with the final premium payment of the 64 individuals still living at that point, to meet the $64,000 in death claims due at the end of the 99th year. Interest on the reserve of $61,305 shown at the beginning of the 99th year is $1,533.

The reserve of $61,305 plus interest of $1,533 when added to the previous year's reserve plus interest of $1,162 gives a total of $64,000, the exact sum needed to liquidate the full obligation to the 64 members remaining of the original 35-year-old group of 93,738. The books are balanced through scientific equity.

**Estate Analysis**
Development of the level premium made it possible for the life insurance industry to offer a new service, that of helping people provide for their overall financial needs.

An individual has only one basic financial problem. That is to create an estate that will provide cash or income exactly when needed. Dividing the estate into two parts simplifies the problem. There is the growing estate during life and the accumulated estate at death.

Both kinds of estates are important and they need to be kept in balance. The estate during life accumulates cash for emergencies and provision for old age. The accumulated estate at death provides cash and income for dependents. If either estate is missing at the time it is needed, hardship and suffering result.

If a person tries to concentrate on some type of savings-investment plan and eliminates the protection of life insurance, his financial plan is out of balance. Such a plan might work if the person using it can get by three big "ifs":

①If he can stay alive long enough to meet family responsibilities. One out of three men dies before retirement age.

②If he can save enough, save consistently, and keep what he has saved. Most savings plans are intentions rather than realities.

③If he can arrange to die or retire at just the right time, when his investments are at peak value. In fact, values are always fluctuating. A forced sale during a period of depressed prices could mean disaster.

It is also possible, however, to overload financial plans on the protection side. Before the time of the level premium, all life insurance could do was meet the hazard of premature death. It could not make anything available for the living needs of the policy owner. He could only try to accumulate a separate reserve for old age and emergencies, but few people were able to do that because of the three "If" barriers.

**Wills and Trusts**

Like insurance, there are many forms of wills and trusts that can be created to fit the needs of each person. Only a qualified attorney with knowledge of applicable federal and state law requirements should draft all such documents. Some of the prevalent instruments are these;

Simple will- A will in its simplest form transfers property owned by the deceased spouse to a surviving spouse, children and other heirs.

Will with Contingent Trust- A bit more complex. The trust is usually created by terms of the will in situations involving minor children. Everything is passed to the surviving spouse. If there is no survivor, assets go to an asset management trust for the minor children until some age at which can be distributed.

"Pour-over" Will- This can be used when an individual with a living trust wishes to merge assets not transferred to the living trust during the person's lifetime and places or "pours" them into the trust. These assets are generally subject to probate, as with a will.

Living Trust- An *inter vivos* trust, taking effect during the grantor's lifetime. It does not avoid estate taxation, but is useful in shifting asset ownership. This trust is beneficial if the beneficiaries are not yet ready to inherit the assets outright, due to age or inexperience in managing affairs.

**Custodians of Wealth**

Life insurance companies operating under the level premium arrangement are custodians of large sums of money put in reserve to provide for death claims to be paid many years in the future. The companies must invest these funds in a prudent way and make a strict accounting of them, because they are guaranteeing future delivery of a definite amount of money under every insurance contract.

Operating as depositories of large funds, insurance companies as investment experts and trustees of policy reserves under long-term guarantees provide a valuable service beyond that of mere term insurance protection.

The premium payments made by policy owners in excess of those required for term insurance are accumulated as policy reserves. Amounts equal to these reserves, except for appropriate reductions during early policy years, are available to living policy owners as increasing cash values on surrender of or as liens against the policy. The life insurance contract provisions guarantee the availability of those cash values and the increasing amount available in each successive year.

In this way life insurance, while primarily designed to provide protection in the case of the insured's death, has developed into a balanced service providing a financial contract that can solve the basic financial problem--the need for money--whether the insured person lives or dies.

This kind of policy, called permanent life insurance, provides an easy and systematic way for the individual to build an adequate, balanced estate. He gets regular reminders to put money into the plan in convenient installments with an element of compulsion. Spending temptations are lessened and a safe, convenient place is provided to create a large guaranteed fund immediately available in case of death and, during life, building a guaranteed and ever-increasing cash value, all without worries over investment or reinvestment of capital.

**Rate Variations**

Contracts for any specific age, such as 25, 30, or 35, may vary widely in rates. A $1,000 policy, for example, might be purchased with premiums for a few dollars, or for $50, $75, or even $100. The difference would lie in reserves required to fulfill the promises made in different kinds of contracts. The greater the cash values in the policy, the greater the reserve required, and naturally the higher the premium.

Buyers of insurance make a choice of the type of contract they feel will be best for them. It is not a question of whether a life insurance policy is "more expensive" or "less expensive" any more than putting $500 in the bank is "more expensive" than putting $200 in the bank.

If a person buys a policy with a $50,000 cash benefit and selects term insurance, he is disregarding any need for cash values. If he buys a whole life policy at a higher premium, he has death protection with a moderate amount of increasing cash values. A limited pay life policy gives the same kind of protection but lets cash values accumulate faster or makes it possible to pay for the policy more quickly. An endowment policy, with the highest premium of the four types, puts even greater emphasis on a rapid increase in cash values.

The life underwriter's chief function is to guide purchasers in making a choice of the most appropriate kind of life insurance. That is why the underwriter needs to understand rate structure and cash values of insurance.

The cash value is the amount the company will pay the insured in cash if he or she decides to give up the policy, in effect selling it back to the company. Thus the policy holder always has a guaranteed buyer for the policy and also a guaranteed selling price. The cash value is also the amount the policy owner can borrow on the policy for emergencies.

In later years of the policy, the cash value and reserve are the same, but in earlier years the cash value is slightly smaller than reserve. This is because the company must make an allowance to protect itself from the adverse effects of cancellations and borrowing.
A company must spend money to operate, and a new policy is an expense to the company for several years.

The company also must allow for "adverse selection" because policy holders who know their health is impaired are less likely to surrender their policies than those who feel they are in good health.

Capitalization of life values is possible through the "callable bond sinking fund" established by life insurance. The sinking fund's monetary value, small at inception, increases until it accumulates to face value. The callable side, applicable in case the insured dies prematurely, starts at near the face value and decreases. It reaches zero at the same time the sinking fund reaches face value. At all times during the policy period the two values equal the face value of the contract.

Level premium construction is made possible by charging more than currently necessary in the earlier years of a policy and thus creating a fund for the heavier mortality charges of the later years. Excess premiums collected in the early years are placed in the legal reserve fund and invested in order to earn interest.
With the development of lifetime protection made possible by these insurance arrangements, life insurance in addition to death benefits now makes possible financial stability whether the insured person lives or dies. Adequate coverage creates an estate that during a lifetime accumulates cash for emergencies and old age benefits. At death it provides funds to protect survivors and prevent forced liquidation of property.

Health insurance, originally a casualty line developed primarily for the protection of travelers, grew into a major partner of life insurance in the protection of human life values after the establishment of group health coverage during the Depression years.

Adequate health protection, in addition to reimbursing medical expenses and stimulating adequate health care, plays a major role in modern business. Group coverage of employees is a basic factor in the American health care system. Insurance companies function to finance the costs of health care, rather than having it provided directly by the government. The direct medical relationship between individual patients and health care providers is thus on a private basis allowing freedom of choice.

With insurance funding, many creative arrangements can be made to add security to business operations and make possible orderly transition of ownership. One of these is the Section 303 Plan for retaining the family interest in a business while providing liquidity to meet death expenses of the owner.

Others include buy-sell agreements, business loan insurance, executive bonus insurance plans, deferred executive compensation plans, key person insurance, split dollar insurance, and qualified retirement plans.

To calculate its rates a company depends on a normal group of lives carrying through on their contracts. Some adjustment must be made to offset the possibility that lapsing and surrendering of policies might leave the company with only bad risks.

**Long-Term Investments**

The life insurance company invests its reserves in long-term securities not due to mature for many years. If a large number of policies were suddenly surrendered, the company might have to dispose of such securities at a loss, or it would have to carry a large amount of cash on hand at no interest.

For these reasons it is necessary that when policies are surrendered for cash, especially during the early policy years, the cash values should be less than the full reserve. The difference is less each year until in later years the cash value and the reserve are the same. Age and sex of applicants are not separate rate factors in themselves, but part of the mortality element. The older the applicant, the shorter his or her expected life span, the higher the risk, and the greater the premium.

The sex of the applicant has an opposite effect on the mortality factor in the case of a female, who is expected to live a few years longer than a male of the same age. Female rates are thus a little lower than those shown in the male table. Some companies have unisex rates, now required by law in some states.

Regular rates and values are based on healthy people who lead normal lives and are not working in hazardous jobs. Risks who do not measure up to standard requirements are called substandard. A company accepting such a risk charges an extra premium.

Issuing a policy costs a company money. Although many of these costs are the same for a large or a small policy--such as paper, printing, accounting, mailing, and general overhead--obviously it costs more to issue ten $1,000 policies than one $10,000. Therefore the part of the larger policy's rate determined by the expense factor is lower than that of the smaller policy. Many companies offer reduced premium rates on large policies.

A variation in premiums occurs because different types of companies use different "loading" depending on how the company is organized and managed. Legal reserve life insurance companies may operate as stock companies, mutual companies, mixed companies, or fraternal insurance associations.

A stock life insurance company is owned and controlled by stockholders who invest their capital in it. Policies of such a company typically are issued on the guaranteed or nonparticipating plan, in which moderate loading is added to the premium to ensure normal safety. If the premiums are not enough, the capital contributed by the stockholders is used to make up the difference.

In return for this risk, the stockholders are entitled to a return on their investment in the company. The stockholders do not own the legal reserves, which are held in trusteeship to fulfill promises made to the policy owners.

A mutual company has no stockholders. It is a cooperative association in which the policy owners are owners of the assets and control the management. There is no invested capital to cover excess losses, so the gross premiums charged by the mutual companies include a loading which covers both operating expenses and a margin to take care of unexpected losses. The unused portion of this margin is returned in the form of dividends to policy owners. These policies are called participating policies.

Some companies have capital stock but distribute surplus to policy holders according to some definite arrangements. Such companies usually write both participating and nonparticipating business and keep

them segregated.

Fraternal associations are based on lodge membership established on religious, ethnic, occupational or other lines. Most fraternal life associations are legal reserve fraternals which operate on the same basis as other legal reserve companies. They have no capital stock and are managed by officers elected by the members. Some tax benefits are granted because fraternals provide charitable and benevolent services to their members and communities. Fraternals are required to have open contracts under which reserves are subject to liens if necessary in order to avoid receivership.

All legal reserve companies use the same mortality tables and employ the same formulas to compute basic rates and reserves. All must qualify under the same minimum standards of solvency to do business under state laws. It is not the type of organization but the integrity of management and the underwriter's service in providing suitable policies to meet individual needs that make life insurance fulfill its purposes.

**Benefits of Creative Functions**

Life insurance originally was purchased as a death proposition, with no profit motivation to the insured. It was regarded as a philanthropic benefit for family dependents. More recently life insurance has come to be seen as highly creative for the payor of the premium in at least four important ways.

1. Elimination of fear and worry: These human traits make many people unwilling to undertake economic pursuit of real merit because they are afraid to use existing capital profitably as long as the risk of death or personal disability is a consideration. The elimination of worry and fear stimulates personal initiative and greater productiveness. While protecting the insured's existing capital, it enables him to obtain commercial credit and enlarge his ventures beyond the limits of his existing capital.

2. Greater creation of estates: The significant factors in business pursuits are thrift and investment. There must be the one before there can be the other. Unless inherited or derived from owned property personally accumulated, capital must be accumulated through personal thrift on an installment plan before it can be invested for financial return. Thrift is the cause of that which is invested, and investment is the result of human thrift. Causes reducing thrift include laziness and failure to save consistently, lack of a system or plan, and inability to keep what has been saved. These handicaps can be overcome when the head of the family, the insured, realizes the services of legal reserve life insurance to himself or herself as the premium payor.

3. Life insurance as property insurance: Although insurance is classified in two broad divisions, life and property, a payor of life insurance premiums is also protecting his property estate. Loss to the estate through final illness expenses, funeral costs, probate and other court costs, and inheritance and estate taxes may be avoided.

With the death of the owner, business and professional good will acquired through years of service represent a property loss unless covered by adequate life insurance. The same is true for marketable assets lost through death of the owner, such as the cost of education, training experience, the cost of educating employees, and advertising during the formative years of a business or professional enterprise.

4. Life conservation: Just as properties are inspected regularly in the interest of loss prevention, the insured person finds a creative service in the area of life insurance when he undertakes regular and frequent inspections to protect the human life against death or disability risks.

Life conservation efforts represent the most sensible investment the insured can make for himself and his dependents. Time is of the essence in discovering serious ailments which can now be cured or controlled. Keeping a healthy person healthy assures the continuance of the creative functions of life insurance for the holder.

**Insurance as Will**

The life insurance policy is a will. Often the larger part or all of a personal estate is made up of the capitalized worth of that portion of personal earnings devoted to family support. The life insurance policy represents a will bequeathing to survivors the money value of the economic forces within an individual. It creates an instant estate at the stroke of a pen.

The life will has advantages over the property will. It is simple and unambiguous, leaving little or no chance for legal disputes. Probate court action is not required to carry out its terms. Prompt payment is made to the beneficiaries without attorneys' fees, executors' fees, court costs, or publicity. The life insurance estate is self-administered. There may be inheritance and estate tax advantages.

**The Role of Health Insurance**

Development of health insurance in this country began more than one hundred years ago, but only reached major proportions during the Depression decade of the 1930s.

Accident insurance, employers' liability, and workmen's compensation coverage mainly were provided by multiple- line casualty insurance companies. In the 1930s, life insurance companies entered the field of health insurance. By 1950 they were writing more than half of all individual health coverage.

The first company to offer insurance against the cost of medical care was the Massachusetts Health Insurance Company of Boston. The first accident policy was issued by the Franklin Health Assurance Company of Massachusetts, organized to offer this type of policy.

Health insurance owed its early growth mainly to coverage against travel accidents, as travel was a dangerous activity in the latter part of the 1800s. Travelers Insurance Company of Hartford, formed in 1863, was the first company organized to insure against railroad accidents.

The first disability policy was offered in 1890. Surgical and hospital expense benefits were introduced into some individual disability policies in the first decade of the twentieth century. The first guaranteed renewable, noncancellable disability income policy was issued in 1907.

**Group Policy Development**

In 1932 the first Blue Cross employee benefit packages were introduced. The idea soon spread nationwide. During the 1940s Travelers, Aetna, and other established companies entered the field. Liberty Mutual Insurance Company in 1949 issued the first major medical expense policy, protecting families against catastrophic illness.

Massive federal and state programs of Medicare and Medicaid began in the 1960s. These have been modified as social changes dictated.

Formerly incurable or crippling diseases have become treatable, but the treatment is expensive. Lengthening lives means lengthening care. The average life expectancy of 46.3 years for men and 48.3 years for women in 1910 has been increased by almost three decades and continues to rise.

After World War II, the majority of US citizens had a company sponsored insurance plan, and the U.S. was the only rich nation where this was the case. Companies began offering insurance policies during World War II to attract talent from the reduced supply of workers, a practice later cemented by tax policies that encouraged untaxed benefits (such as health care) rather than taxable ones such as cash. Offering insurance in lieu of cash compensation made corporations responsible for their employee's health. As time passed, rising insurance costs coupled with rising salaries squeezed both benefits and salaries. Something had to give, and this manifested as a large number of uninsured Americans.

**ACA**

The Affordable Care Act (ACA) or Obamacare includes numerous provisions that take effect between 2010 and 2020. Policies issued before 2010 are exempted by a grandfather clause from many of the changes to insurance standards, but they were affected by other provisions. Beginning in 2014, changes to the program included:

- Guaranteed Issue- prohibits insurers from denying coverage to individuals due to pre-existing conditions, and a partial community rating requires insurers to offer the same premium price to all applicants of the same age and geographical location without regard to gender or most pre-existing conditions (excluding tobacco use).
- Minimum standards for health insurance policies are established.

- An individual mandate requires all individuals not covered by an employer sponsored health plan, Medicare, Medicaid, or other public insurance programs (such as Tricare) to secure an approved private-insurance policy or pay a penalty, unless the applicable individual has a financial hardship or is a member of a recognized religious sect exempted by the Internal Revenue Service. The law includes subsidies to help people with low incomes comply with the mandate.
- Health Insurance Exchanges operate as a new avenue by which individuals and small businesses in every state can compare policies and buy insurance (with a government subsidy if eligible).
- Low-income individuals and families whose incomes are between 100% and 400% of the federal poverty level will receive federal subsidies on a sliding scale if they purchase insurance via an exchange. Section 1401(36B) of PPACA explains that each subsidy will be provided as an advanceable, refundable tax credit and gives a formula for its calculation. Consumers can choose to receive their tax credits in advance, and the exchange will send the money directly to the insurer every month. Small businesses will be eligible for subsidies.
- Medicaid eligibility expanded to include individuals and families with incomes up to 133% of the federal poverty level, including adults without disabilities and without dependent children. The law also provides for a 5% "income disregard", making the effective income eligibility limit for Medicaid 138% of the poverty level. Furthermore, the State Children's Health Insurance Program (CHIP) enrollment process is simplified. However, in National Federation of Independent Business v. Sebelius, the Supreme Court ruled that states may opt out of the Medicaid expansion, and several have.
- Reforms to the Medicare payment system are meant to promote greater efficiency in the healthcare delivery system by restructuring Medicare reimbursements from fee-for-service to bundled payments. Under the new payment system, a single payment is paid to a hospital and a physician group for a defined episode of care (such as a hip replacement) rather than individual payments to individual service providers. In addition, the Medicare Part D coverage gap (commonly called the "donut hole") will shrink incrementally, closing completely by January 1, 2020.
- Businesses which employ 50 or more people but do not offer health insurance to their full-time employees will pay a tax penalty if the government has subsidized a full-time employee's healthcare through tax deductions or other means. This is commonly known as the employer mandate.

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**Uses of Health Insurance**

A teammate of life insurance in the protection of human life values, health insurance has as some of its major functions the following:

- Income replacement: For most people, inability to work means that income stops or is drastically reduced, and the primary function of health insurance is income replacement. During the disability, personal and family expenses continue. Without means to meet them, the individual and family become a burden on society. Health insurance to replace income is regarded as primary because it keeps the family together with a roof over their heads and bread on the table.
- Reimbursement of medical expense: Costs of medical care in case of serious illness or injury have risen enormously, and meeting these costs has tended to overshadow the basic income-replacement function of health insurance. Many people feel impelled to have medical expense coverage before insuring their income against cessation because of disability.
- Doctors and hospitals have an obvious interest in the spread of health coverage. Not only does health insurance ease the problems of the insured and his family, but also those of the doctor and hospital. Care paid for by insurance proceeds is a principal source of income for them.
- Medical expense insurance is available on many different plans. The broad unallocated type of coverage exemplified by major medical expense insurance reimburses for nearly the entire spectrum of expense without limit as to particular types, subject to coinsurance provisions and an over-all maximum amount.
- Stimulus to adequate health care: Lack of personal means has caused many people to defer seeking needed medical care, even though facilities are available to provide treatment to indigent persons. When the financial obstacle to early and adequate treatment is removed through insurance funds, the

way is opened to speedier recovery. The existence of a sound insurance program provides peace of mind which can alleviate tension and the fear of insecurity which in themselves can cause illness or make it worse.

- Maintenance of credit: The income producer, changed by disability into a large-scale consumer, can see credit crumble without the income provided by health insurance. Creditors like to see adequate plans of health insurance. To prevent delinquencies on installment purchases, creditors offer plans of health insurance with benefits payable in the amount of the loan obligation if the insured is disabled. Health insurance to protect mortgage loan obligations is also available.
- Safeguard for the insurance estate: Other insurance is insured by health insurance. Life insurance and property insurance payments may be kept up by the benefits of health insurance in times of emergency.
- Business insurance: Many important uses of health insurance are now of financial value to business enterprises. Health insurance, once thought of as the principal support of the individual and family during the disability of the breadwinner, now plays an important part in business key man insurance and overhead expense indemnity. Disability of a sole proprietor, business partner, or corporation key man confronts an enterprise not only with the loss of services but with the necessity of continuing compensation while hiring a replacement. Such a financial burden for some businesses can be bankrupting if long continued.
- Health insurance also is a vital factor in providing the means of implementing buy-and-sell agreements that become effective in the event of prolonged disability of one of the parties. Health insurance now has come to serve business as one of the most important means of improving employer-employee relations, increasing productivity, and attracting and keeping good people.
- Health conservation: Like many other lines of insurance that make their most important contribution in preventing the hazard underwritten, health insurance is a major factor in easing the disability problem. Just as steam boiler and machinery insurers promote safety by providing inspection services, health insurers encourage their policy holders and the general public to be safety conscious and to take timely steps to prevent or cure illness. The insurer supports the educational work of the Public Health Service, doctors, and hospitals, although the nature of the individual health hazard limits what the insurer can do to prevent illness and injury.

**Voluntary System Advances**

Under the American system, insurance companies function to finance the costs of health care rather than actually to provide such care. Thus they do not interfere with the relationship between the patient and his physician or hospital. By supplying the financial means for securing care. Insurance companies help preserve the traditional freedom of choice for the individual who needs medical treatment.

Competition in the health insurance business has produced a wide variety of contracts and benefits. No field of insurance offers a greater variety of insurers in terms of organization or benefit type. The principal division of the business between insurers providing cash benefits and plans offering service benefits has encouraged competition and stimulated improvement of all plans. Voluntary health insurance has provided major support to the American system of private enterprise.

**Business Insurance Systems**

Life insurance can be used in special ways to provide security in the field of business operations. A major concern for a business owner is almost always the question of what will happen to the business after his death. Businesses can die too, and many do, if there have been no sound arrangements made for conserving the value and passing an intact operation on to heirs or successors.

**The Section 303 Plan**

Many owners of small businesses want to see them continue in the family when there is a member of the younger generation ready and willing to take over. If the business is incorporated and the owner's stock in it makes up the bulk of his estate, the need for cash to cover death and estate expenses may be so severe that it could put an end to the business itself.

Section 303 of the Internal Revenue Code allows a corporation to redeem all or a portion of a decedent's stock, other than that which would be taxable as a dividend. Cash for estate tax and other expenses can be provided under a Section 303 redemption. The following steps are required in a Section 303 redemption;

- °The redeemed stock's value is included in the gross estate of the decedent
- °The value of the stock that is included in the decedent's estate must be greater than 35% of the

adjusted gross estate.

- °The limit on the amount of stock that can be redeemed and still receive favorable federal estate tax treatment is as follows; All estate, generation skipping and state inheritance taxes plus the funeral and administration expenses associated with the stockholder's death.
- °The corporation must purchase the decedent's stock form the person responsible for paying the estate taxes and administrative expenses.

A rancher, for instance, almost lost his land and cattle operation when his father, the original owner, died and there was not enough cash on hand to take care of death expenses and estate taxes. Although the current owner managed to keep the operation and build it back up, he does not want his son to have to go through the same thing. The ranch is now incorporated. Under Section 303 of the Internal Revenue Code, the corporation is allowed to redeem enough of its stock from the owner's estate to pay expenses after his death.

A $500,000 insurance policy on the owner's life, with premiums paid by the corporation, will result in payment of death benefits to the corporation when the owner dies. The cash will be used to purchase the owner's stock from his estate. The estate then has the funds from proceeds of the policy to pay death expenses and taxes. The remaining interest in the business goes, by the owner's will, to his son. Through this partial redemption the family retains ownership of the business, which can continue as before. This arrangement makes it possible to get non-taxable cash out of the corporation when it is needed.

There must be funds available in order for the corporation to be able to redeem shares from the decedent's estate. If the corporation has fund available in cash to make such a redemption, a potential problem arises. According to IRS regulations, a corporation with more than $250,000 on hand may have "excess retained earnings" and be subject to a penalty. As with all business plans, tax rules here can get pretty complex. Accurate analysis of any particular situation is necessary to determine eligibility and usage of a Section 303 plan.

To qualify for a Section 303 stock redemption, specific percentage tests must be met as to the total value of each owner's personal and business assets. The insurance agent will need to confer with the corporation's attorney and accountant to work out the necessary details. Premiums paid by the corporation for the policy are not tax deductible, but death proceeds received are not taxable to the beneficiary and proceeds received by the estate for the sale of the stock are not subject to estate taxes.

**The Cross-Purpose Buy-Sell Agreement**

Owners wanting to plan for a smooth transition in ownership if one dies, might do so with a written agreement. This would provide that the interest of Partner A will be purchased by Partner B if Partner A dies first, and vice versa.

To provide the cash to make the arrangement possible, each partner agrees to apply and pay for an insurance policy on the other's life. The policy is to be owned by the buyer, who is also the beneficiary. Each will pay the premiums to the insurance company. If Partner A dies first, the life insurance company will pay the death benefits to B, who then will pay this cash to A's estate in return for A's interest in the company. The same provisions will work in reverse if B dies first.

There are in general three ways of disposing of a business when the owner dies. It may be retained by the family, liquidated, or sold intact to a willing buyer.

Sometimes it is impractical to try to keep a business going after the owner's death if he has been the main figure in its operation and there is no one in the family willing or able to carry on. In such a case plans need to be made for orderly liquidation of the business at the owner's death. These probably will require life insurance on the owner equal to the difference between the actual value of the property to be liquidated and the liquidation value, which may be much less.

If there is a family member willing and able to take over the business, or if there is an outside buyer willing to purchase it, there should be insurance equal to the value of the interest to be transferred so the full dollar value of the business interest can be retained while the transfer is made.

The buy-sell agreement makes it possible to sell a business as a going concern, maintaining its full value. It avoids disruption of the business through the owner's death and possible liquidation of business properties at a loss in order to pay death expenses and estate taxes. The two key factors in a buy-sell agreement are a contractual arrangement between the parties involved and life insurance to fund the purchase of the business at the necessary time.

Under current tax laws, the cross-purchase agreement is often preferred to an entity purchase agreement because the surviving owners under a cross-purchase have a higher cost basis for their shares. This is important under capital gains tax provisions because it will mean fewer taxes on the gain if a survivor later sells his interest.

**Business Loan Insurance**
A business owner seeking a loan for expansion may take out a life insurance policy in an amount equal to the original amount of the loan, naming the lender the beneficiary. The death benefit is made to equal the amount of the outstanding balance on the loan at the time death occurs. Any death proceeds beyond this amount would be paid to the business owner's other designated beneficiary or to the business itself. Through this plan the bank is assured that the loan will be repaid whatever happens to the borrower. The borrower is able to obtain the loan because it is guaranteed.

The arrangement is similar to credit insurance required for an individual buying a car or a home. The lender often provides insurance for the buyer in such a case, but at a cost which includes a seller's commission on the insurance policy. Therefore it is to the seller's interest to provide as expensive a policy as possible.

By buying life insurance through a separate agent it is possible to secure a more cost effective policy than one purchased through a lender. It will be a policy tailored to individual needs, and one that can be converted when the loan is paid off into another plan, changing the beneficiary from the lender to the business. Death benefits going to the creditor or to the owner's beneficiary under business loan insurance are not taxable.

**Executive Bonus Plan**
Insurance policies can be used in an executive bonus plan, called by the IRS a Section 162 plan, to the advantage of both employers and employees.

Under this plan a company which has been giving year-end bonus payments makes them in the form of life insurance policies instead of cash. The amount of the bonus is paid to the insurance company as an annual premium instead of in a check to the employee. The employee is notified of the amount of the bonus in his W-2 form at the end of the year and pays tax on it, receiving the face value of the life insurance protection for just the cost of the additional tax.

The premium payments are tax deductible for the business making them because they are employee compensation, just as cash bonuses are. The recipients pay income tax on them just as they do on cash bonuses, but they receive something more valuable than cash. They have ownership of a large insurance policy at a small cost, just the income tax the pay on the premiums.

The arrangement also is an advantage to the employer. A small company that cannot afford a large benefit package still can offer competitive fringe benefits by giving large bonuses (the life insurance face value) at small cost (the tax-deductible premium payment).

The employee is the policy owner and can do what he likes with it, borrowing on it if necessary, assigning it as security, cashing it in, or keeping it for estate liquidity. When the employee dies, death benefits are payable to his designated beneficiary.

If the corporation is in a higher tax bracket than the individual, the owner-employee of a small business can pay out bonuses deductible from the corporation's tax at its rate and have them taxed to him or other employees at their individual tax brackets. The executive bonus plan has the advantages of being simple, easy to understand, and easy to administer.

**Deferred Executive Compensation Plan**

A way to encourage key employees to stay with a company has been found in a plan offering, through insurance, a guarantee of future compensation in addition to regular retirement income. This is the deferred executive compensation plan.

If a key local news anchor, for instance, was about to be hired away by another TV station, his current employer might offer him $15,000 a year for ten years beginning at age 65. If he left his current station, he would give up this promised payment. The station would take out a $150,000 insurance policy on the anchor man's life. As the purchaser, owner, and beneficiary of the policy, the station would pay the premiums on the policy to the insurance company. As the beneficiary, it would receive tax-free the death benefits of the policy in case of the key employee's death.

The deferred compensation agreement between the station and the anchor is separate from the insurance policy which funds it. Under this agreement, the station must make tax-deductible payments to the anchor man when he retires. It can fund these payments either by cashing in the policy, by borrowing on it, or by using cash set aside for this specific purpose. If the anchor man dies before receiving his deferred compensation, the station can use the $150,000 in death benefits to make tax- deductible payments to the employee's beneficiary.

The money received by the employee or his beneficiary will be subject to income tax. These payments are deductible to the station. The premiums the station was paying on the policy, however, were not tax deductible, so the plan is classified as "nonqualified" and can be put into effect for any key employee the management wishes. No government approval is required.

The plan provides an incentive for the key employee, giving him compensation for services currently rendered to be paid at some future, pre-determined date. This compensation will not be taxed to the employee until it is received. It cannot be deducted by the employer during his current contributions through premium payments on the plan, but the benefits to be paid out in the future will be deductible.

Such a plan generally is attractive to an individual who has enough income for current needs but wants to provide additional security for the future. Both employer and employee must be in good financial shape and expect to remain so for this plan to be successful. To achieve tax benefits the plan must rely on the employer's unsecured promise to pay benefits in the future. Therefore the plan and the insurance policy used to fund it must be separate.

There is no guarantee that funds will be on hand to pay retirement or death benefits unless the employer holds an insurance policy on the life of the key employee. The employer owns the policy, pays premiums on it, and is the beneficiary. If the employee lives to the date he is to receive deferred compensation benefits, the cash value of the policy should be available to pay all or part of the benefits due. If the employee dies before receiving the deferred benefits, the death benefits will come tax-free to the employer and under the terms of the agreement may be paid out to the employee's beneficiary.

Another advantage of using life insurance as funding for deferred compensation is that waiver-of-premium benefits can be used if the agreement calls for disability payments in case the employee becomes unable to work before retirement age. Premiums waived on the policy would free cash to go toward the payment of disability benefits.

Cash benefits building up on the life insurance policy are free of current income tax, which is not the case with any other type of uninsured sinking fund.

The employer has flexibility in the way he will pay retirement benefits when the funding is done by life insurance. They may be paid out of cash values of the policy, out of other current assets, or in any other combination the employer wishes. If the policy is to be kept intact, benefits will go to the employer on the employee's death, tax-free, and any death benefits payable to the employee's beneficiary can be made out of those tax-free proceeds.

The plan is attractive to many small business owners because it can be discriminatory. The government has no say in which employees may receive it. It is also attractive because eventually it will cost the

employer little if anything. The insurance agent is selling cash for employee retirement, cash to hold key employees in the firm, or cash for the employee's beneficiary on his death, in the cheapest way cash can be purchased-- through life insurance.

**Key Person Insurance**
Almost any well established business will have insurance coverage for its plant and equipment, but many small operations which plow most of their profits back into the business have little liquidity with which to meet the emergency loss of a key executive.

If a small business depends on key persons in three or four departments and one of them dies, the firm is suddenly deprived of that individual's talent and experience. If the person is in sales, customers are likely to fall away; if in production, a massive tie-up may freeze the business in its tracks. It takes time and money to replace such people and restore operations to normal. Lending institutions, knowing the situation, are not likely to be willing to make such tide-over loans. The business which is protected by insurance on the lives of its key people has a great advantage over an unprotected firm. It has income tax free dollars with which to replace lost profits and return to normal operations.

Key person insurance is a means of protecting against lost profits, of assuring liquidity after the death of a key executive, and of showing financial integrity to assure creditors, customers, and employees that the business can and will continue.

A small business with one or two owners who are very active in day-to-day operations is an especially promising prospect for purchasing this type of insurance. In determining what coverage is needed, the insurance agent can ask the owner to estimate what it would cost to replace the person in question. There are also formulas available based on multiples of the salary paid the key person or multiples of the average annual net earnings of the business which are attributable to the person's ability.

Premiums paid by the employer on key person insurance are not tax deductible, but death benefits received by the company are not taxable. It is necessary for the named insured (the employee) to know that he or she is insured under a key person plan.

**Qualified Retirement Plan** Social Security was never meant to take care of all retirement needs. It was designed only as a supplement to private retirement funds. The problem is how to provide those funds. Under the tax laws of the United States, there is a way in which businesses can provide for their employees' retirement needs with money they otherwise would be paying in income taxes.

There are two reasons for such a tax provision. First, retirement funds provide a decent living for individuals who have worked hard all their lives but who cannot in their old age support themselves and their families on Social Security alone. Second, the regular payments into investment funds by those who are taking part in a retirement program help in the capital formation necessary for national economic growth and security.

Under a qualified retirement plan, a business owner can create a trust and make tax-deductible contributions to it. These contributions go into two accounts. One is an insurance account and the other is an investment or annuity account.

Out of the insurance account, premiums are paid to the insurance company for current life insurance protection for employees. If an employee dies before retirement age, his beneficiaries receive death benefits. The portion of the trust funds used for this current life insurance is considered to be an economic benefit received by the employees and is therefore taxable to them as income, using the government's P.S. 58 rates for term insurance. The death benefit, however, if correctly structured, may be tax-free to the beneficiary.

The other portion of the trust that for investment, provides money which is used to fund retirement benefits. This money is invested by the trust and increases with regular contributions and with tax-free interest.

When the employer and covered employees reach normal retirement age, the insurance company handling the trust pays them retirement benefits out of the trust funds. Restrictions can be built into the plan to keep from having to pay retirement benefits for those who have worked for the employer only a few years.

If an employee receiving retirement funds dies, the insurance company will pay a death benefit to his designated beneficiary. This payment, and the retirement payments received while the employee was alive, is taxable to the employee or beneficiary. Qualified retirement plans can be designed for any type of business, large or small. For a sole proprietor or a partnership, an IRA or Keogh plan may be suitable. Corporations may set up qualified pension plans, qualified profit sharing plans, a combination of these, or other more complicated arrangements. The general function, however, remains the same. The current life insurance protection for covered participants may be present or absent in the plan.

The Keogh plan is designed to provide retirement benefits for self-employed, unincorporated individuals and their employees. It works in the same way as the corporation plans, with or without current life insurance protection. The investment funds increase tax-free to provide retirement benefits and post- retirement death benefits. Generally these benefits are subject to income tax, although five-year averaging provisions may be used if the benefit is received in a lump sum.

Both qualified corporate retirement plans and Keogh plans have to conform to certain standards to receive government approval under the federal tax laws. The plan must be set up on behalf of employees and cannot discriminate in favor of the "prohibited group" of officers, stockholders, and highly paid management personnel if it is to qualify under IRS rules for tax- deductible contributions.

It is possible, however, to design a plan that will benefit key employees to a somewhat greater extent than others. The representative of the underwriting company needs to get the information from the prospect to design the plan properly. Most home offices and agencies of insurance companies have experts on retirement plans and ERISA, the Employee Retirement Income Security Act, by which they are governed. The agent fills out an Employee Census Data form showing the names, genders, dates of birth, dates of first employment, and monthly or annual incomes of principals and employees of the business. Percentages of ownership by the principals or owner-employees also should be shown. Key employees should be indicated. Also needed is information on the owners or the corporation's tax brackets and on the amount of money the owners wish to contribute to the plan. Using this data, a proposal designed to meet the prospect's needs can be developed in the agency or home office.

Premiums paid for the life insurance used to fund the plan and for the current life insurance are deductible by the employer. Premiums paid for the current life insurance are taxable to the employee as current economic benefits. Retirement benefits paid from the trust are not deductible to the employer. They are taxable to the employee. The annuitant has 60 days to elect whether the payments are to be taxed as a lump sum or on the installment option basis.

Death benefits received by the trust are not taxable to the trust. Death benefits received by the beneficiary from the current life insurance policy are not taxable, but death benefits received by the beneficiary from the trust are taxable to him; so are continuing retirement payments to the beneficiary received after the annuitant dies.

For the insurance that funds the retirement plan, the trust is the applicant, owner, premium payor, and beneficiary. The employee is the named insured. For the current life insurance option, the applicant is the employer and the premium payor is the trust. The owner and named insured is the employee, and the beneficiary is the employee's choice.

**Split Dollar Insurance**

A solution to some business and personal insurance needs that is sometimes overlooked is the possibility of split dollar insurance. It involves a person who needs insurance and an employer or other person willing to help pay for it.

An employer and a key employee agreeing on a split- dollar policy would divide the cost of the premiums paid to the insurance company for a policy on the employee's life. The part of the premiums paid by the business would constitute a "current economic benefit" for the employer. IRS rules state that the employee must report as income an amount equal to the one-year term cost of the life insurance protection provided less any portion of the premium provided by the employee.

If the employee should die, the insurance company would pay the cash value of the policy to the employer's business. The remainder of the death benefit would go to the employee's beneficiary. Under this arrangement the family would have cash to take care of income needs and the business would recover approximately what it paid into the contract. Split dollar insurance makes the employee able to buy insurance at far less than permanent rates, and costs the business only the loss of the use of the money going for payment of premiums.

The employer's contribution to the plan generally equals the annual rise in the policy's cash value and the employee's payments decline annually, sometimes to the point where they stop. On the employee's death, the employer receives at least the cash value portion of the policy or enough to cover the premium payments, and the employee's beneficiary receives the balance.

Split-dollar is a nonqualified plan because the employer chooses which employees he wants covered, making it useful as a fringe benefit for key individuals. It also can be used to fund the buy-out of a sole proprietor on his death by making the employer the insured and giving the employee the cash necessary to buy the employer's interest when he dies.

Variations of the plan can fund cross-purchase buy-sell agreements to help the business itself share in the cost of funding buy-outs. Split-dollar insurance also can be set up for family situations. Premiums paid by the employer are not tax deductible, as this is a discriminatory plan. These premiums are taxable to the employee as a current benefit. Premiums paid by the employee are not deductible. Death benefits paid to the employer and to the second beneficiary are not taxable.

**RECAP**

Life and health insurance are income protection products, protecting against the permanent or temporary absence of earned income. Thus they are in the category of human life value insurance as distinct from property value insurance. Originally life insurance was regarded purely as "death insurance," to protect survivors with no personal benefit to the insured. This attitude changed with the development of the human life value concept. By analyzing basic economic risks facing individuals and developing scientific ways of meeting them, this concept made possible an overall appreciation of the practical value of human life.

The expected income flow based on an individual's earning power extended through an average working lifetime can be appraised and capitalized for insurance purposes. Human life values in the United States under this system would give a monetary total of about five times that of property values in the country.

Fundamental principles of property values, such as appraisal, indemnity, accounting, and accumulation of surplus, can be applied to the larger and more significant human life values through life and health insurance. These protect against the major hazards to earning capacity and human life values: premature death, or "casket death," disability, or the "living death," and compulsory retirement, or "retirement death."

# CHAPTER THREE Group Insurance

Employees generally now see insurance coverage as part of their total compensation rather than as an extra privilege. The more attractive a company's group insurance program is, the better its success in recruiting and keeping quality employees will be. Group insurance usually includes life insurance, health insurance (medical, surgical, and hospital), and disability income insurance.

**Designing Group Insurance Coverage**

**Group Insurance Advantages**
Group insurance has as its outstanding characteristic the almost unlimited number of individuals who can be insured under a single contract, usually without evidence of insurability.

The same theoretical principles involved in any type of underwriting apply to groups. The insurance company gains the advantage of risk-handling economies with group insurance. The larger the group, the lower the expense on a per person basis. Thus group insurance can benefit both employer and employees with lower cost and more liberal benefits than otherwise would be available. Because of the broader and more stable age range in larger groups, premium costs can be held down at renewal time. Increasingly, however, insurance companies also have designed coverage for groups as small as two people. These plans usually are standardized life, medical expense and disability income coverage, and they may have specified waiting periods to guard against pre-existing conditions. Underwriting of these plans usually is streamlined to minimize expenses.

**Flexibility Advantages**
It is possible in the design of sizeable group insurance programs to provide a choice of benefits and deductibles that will suit the applicant and be reasonable in cost. Assorted coverage such as life, medical expense, disability income, dental benefits, and other newer offerings are available, and within each type there are variations in benefits and deductibles. The agent who knows how to work with a client in designing a truly suitable package has an advantage over one who simply offers a standardized plan and over the usually nonflexible plans which associations offer. For small groups, the offerings are more standardized, but even these can give the client a choice of benefit schedules.

**Differences in Selling**
Although the agent will be using the same basic skills and techniques in selling group insurance as in selling individual policies, there are differences. Instead of talking to a prospect about his own personal needs, the agent is discussing with a company owner or official the benefits to be offered employees. Most selling of individual policies is done during the evening, while group insurance selling takes place during business hours. The individual insurance policy is going to be paid for with personal after-tax funds, while the group policy premium usually is paid either in part or totally out of company funds on a tax-deductible basis. The premium rate on an individual policy is usually guaranteed, while the premium for group insurance may be experience rated annually or on some other regular basis. The agent will find first-year commission dollars higher on the average than for individual policies. There sometimes are added bonuses or service fees. Both types of policies usually offer renewal commissions.

**Group Prospects**
There are various kinds of prospects for group insurance, but the greatest number will be found in the single-employer category. This also includes the largest number of potential and actual individual insured. Such prospects are to be found literally everywhere. The employer may be a close corporation, a sole proprietorship, or a partnership. Employees eligible for coverage may include proprietors, partners, and corporate owners who are active in their businesses, as well as employees in subsidiary or associated firms and sometimes retired employees. Tax rules may vary for self-employed individuals as opposed to the usual type of employees.

Insurance plans may be set up for multiple-employer groups under trusteeship arrangements between employers and unions, voluntary trade associations, or groups for small businesses represented by trusts established by insurance companies.

Under multiple-employee trust plans, which usually result from collective bargaining between employers and

unions, the employers make regular contributions to cover premium and administrative costs and trustee expenses. Voluntary trade association groups may sponsor group insurance plans for their members in the same type of business or industry. In the case of small group plans in which the insurance company sets up a trust to represent member businesses.

Labor unions sometimes have their own plans with the union as the policy owner, rather than participating in a trustee plan established by a company-union agreement. Under a union-sponsored plan, the total premium may be paid directly from union funds or union members may contribute a portion of the premium.

Depending on state laws and company underwriting rules, various kinds of associations and other groups may qualify for group insurance. These may include professional associations such as those of doctors, lawyers, teachers, or others, as well as religious organizations and veterans' groups. Creditor organizations such as commercial banks, finance companies, credit unions, and retailers may qualify for group life insurance and group disability income plans to protect them against financial loss caused by death or disability of borrowers.

**Self-Insurance**

Sometimes businesses, especially large ones, may consider insuring themselves against certain risks. But in the face of unpredictable costs, most employers prefer group insurance for protecting themselves against unexpected risks that hold the possibility of financial catastrophe. Making level payments to an insurance company makes it possible for an employer to know in advance what his costs will be. Also he is relieved of the responsibility of settling individual claims, establishing his own benefit limitations, or defining disability for individual employees.

Some very large firms self-insure their group life plans, often as salary continuance plans, but most employers have found it highly desirable to use a life insurance company. There are a number of advantages in coverage by an insurance carrier:

**Secure Benefits.** Employees usually appreciate the guarantees offered by a formal insurance plan. The assets and good faith of the insurance carrier back such a plan and insurance companies operate under strict statutory control.

**Shifting of Risk.** Instead of fluctuating risk rates that may prove disastrous, the employer has a predictable cost he can allow for in his budget without having to draw unexpectedly on funds needed for other operations. An insurance company can carry the risk of misjudgment of the underlying claim rate better than an employer can. An insurance carrier also has the advantage of a broad spread of risks and has the financial strength to absorb catastrophic losses.

**Availability of Services.** Problems in an employee benefit program are more complicated than simply paying claims. An insurance company can provide technicians specializing in actuarial, legal, and financial problems. These specialists keep up with trends in actuarial estimates, benefit schedules, labor relations, and legal requirements. They can provide services that the average employer does not have available in-house.

**Efficient Claims Administration.** An insurance company draws on experience with a wide variety of unusual claim situations. Also claim settlement by an insurance company relieves the employer of personnel problems which may arise when a claim is turned down.

**Conversion Privileges.** Insurance carriers are prepared to issue converted policies of individual insurance when an employee leaves a group plan or when a master plan is terminated. This opportunity is not available under self-insured plans.

**Tax Advantages.** Under group life insurance, death proceeds are nontaxable income. There may be a limit on the amount considered nontaxable under self-insured plans, and there are numerous other tax provisions with which insurance company specialists are equipped to deal.

**Settlement Options.** A wider range of benefit settlement plans can be offered by an insurance company than are available under an uninsured plan.

**The ACA**
The Patient Protection and Affordable Care Act (PPACA) commonly called the Affordable Care Act (ACA) or colloquially Obamacare, became law in 2010. It impacts group insurance.

**Establishing Eligibility**
In the design of a group insurance program, the underwriter has two conflicting aims. He wants to make the package so attractive, both in price and in the coverage offered, that employers will want to buy it and employees will want to sign up for it. But he must guard against anti-selection. He must set restrictions to keep the program from being used by individuals for whom coverage was not intended, so that the cost for those who are legitimately covered can be kept as low as possible. Therefore he must establish clear definitions of "employee" and "dependent," and must set rules as to which employers can purchase a group insurance program.

One set of requirements applies to new employees of a company which has a group insurance program already in place. Another set applies when the carrier takes on a new group insurance case, either because the employer has not had coverage before, or because he had coverage with another carrier.

**"Employee" Defined**
It is necessary for the insurance company to establish clear definitions of "employee" and "dependent" in order to avoid anti-selection through the loading up of family members. The employee list is reviewed from time to time by the insurer, but in real life it is not always easy to determine whether a relative of the owner who once was a legitimate employee is still actively at work or whether a dependent child is still really dependent.

In general, requirements call for a legitimate employee to be actively at work full-time. To qualify as full-time, the employee is required to work regularly at least 30 hours per week. Some will provide partial coverage such as a minimum death benefit for part-time employees.

An upper age limit of 65 may be set by the insurer even though the employee is not required to retire until age 70. Group term life insurance under such a limit may either be reduced or terminated, disability income coverage may cease, and health care benefits will cease or a Medicare supplement may be provided.

Beginning in 2015, the ACA imposes a penalty on applicable large employers (ALEs) that do not offer health insurance coverage to substantially all full-time employees and dependents. An ALE may also be subject to a penalty if it offers health insurance coverage to full-time employees and dependents, but the coverage is unaffordable or does not provide minimum value. An ALE is only liable for a penalty if one or more of its full-time employees receives a health insurance subsidy for coverage under an Exchange. A full-time employee is an employee who was employed, on average, at least 30 hours of service per week. The final regulations treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours per service per week.

Requirements for employees exclude corporate officers, directors, proprietors, and partners who are not actually working full time. Under some plans, coverage may be extended only to specified groups, such as long term disability coverage only for salaried employees. Such plans have to be carefully structured, however, to conform to tax, insurance, and labor laws and regulations.

**"Dependent" Defined**
The spouse of an employee usually is covered if he or she is legally residing with the employee. An age 65 limit on coverage for the employee usually applies also to the spouse. If husband and wife work for the same company, the wife cannot be insured both as a dependent and an employee. Usually it would be to her advantage to be covered as an employee in order to obtain death and disability coverage which might not apply to dependents. Dependent children in such a case would be considered the dependents of one parent.

Traditionally, health plans have had significant flexibility in determining which individuals would be eligible to be covered as dependents. However, this flexibility is affected by the health care reform requirement to provide coverage up to age 26.

Whether dependent coverage under a health plan is tax-free (at the federal level) depends on whether the individuals covered as dependents also qualify as dependents under the Internal Revenue Code (the Code or tax code). An individual can qualify as a dependent under the Code by being any one of the following:

- A child of the employee (until the end of the year in which the child turns 26)
- A qualifying child, as defined in Code Section 152
- A qualifying relative, as defined in Code Section 152

Before health care reform, an individual had to be either a qualifying child or qualifying relative to be a tax dependent for health plan purposes. Once health care reform was passed, the definition of tax dependent was extended, effective March 2010, to include "any child (son, daughter, stepson, stepdaughter or an eligible foster child of the taxpayer) who as of the end of the taxable year has not attained age 27."

Coverage for dependent children past the age of 18 is continued now if the dependent is a full- time student, to the upper age limit of 26, or if the dependent is physically handicapped or mentally retarded to the extent that he cannot support himself. Handicapped child coverage is required by many states and continues as long as the child remains handicapped or the master group insurance contract is in force. Maternity benefits are now extended by many carriers to unmarried dependent children under family coverage.

Ordinarily the employee cannot elect coverage for dependents unless he is also insured. In a case where the insurance company is still reviewing medical evidence on the employee, however, or even if it denies health coverage to him on the basis of medical evidence, his dependents may still be eligible for health care coverage provided he has a minimum amount of life coverage.

**Requirements for New Employees**

The new employee who is becoming eligible for group insurance for the first time usually is given one month in which to enroll. He may be subject to various health status limitations.

**Waiting Period**: Under most group insurance plans there is a waiting period so that the employee is not covered for benefits on his first day of work. The period was often from one to six months, but is most commonly three months or less. Small employers adopted a one-month waiting period, controlling abuses through a pre-existing condition clause rather than through an extended waiting period. All employees are penalized by a long waiting period, while the pre- existing conditions clause affects only those with disabilities incurred prior to joining the plan. If an employer is trying to hire the star salesman of a competitor, a long waiting period in the group insurance policy may be discouraging.

In 2014, the Departments of Labor, Treasury, and Health and Human Services released a joint final rule to implement an Affordable Care Act provision prohibiting self-insured and insured group health plans from requiring employees to wait more than 90 days before health insurance becomes effective. The final regulation also contains amendments to pre-existing Health Insurance Affordability and Accountability Act regulations to bring them into ACA compliance. The agencies also released a proposed rule addressing the relationship between orientation programs and the 90-day waiting period.

Other special conditions or requirements of individual companies may enter in when the waiting period is determined. The employer with a long waiting period will eliminate claims for new employees, but they might be the very ones he is most anxious to recruit.

**Eligibility Period**: When the employee becomes eligible for coverage under the group insurance plan after the waiting period, he has a set period of time in which to decide whether he wants to participate in the plan. Usually this time, known as the eligibility period, is 30 or 31 days. The employee probably will accept coverage if the company pays the full cost. The 31-day period also applies to signing up dependents for health care coverage and other benefits. When a new dependent is acquired, through marriage or birth, the employee usually has 31 days to add that enrollment without penalty. This may be a mere formality if the employee already has full dependent coverage, but forgetting to add the new dependents until a claim arises may cause problems.

An employee who rejects coverage for himself or his dependents usually is required to sign a waiver card providing proof that he was offered the coverage and refused it. This requirement is designed to prevent misunderstanding and resultant legal difficulties. If he would wish to pick up the coverage at a later date, he

will have to furnish proof, usually at his own expense, that he is insurable. Some health maintenance organizations (HMOs) have an open enrollment period every year. Others believe that such a practice encourages people to put off joining the plan until they need coverage, and therefore do not have an open enrollment period.

**Medical Evidence:** In small groups, when an employee has elected to participate in a group insurance program, he is required to provide medical evidence as to the status of his health. Insurers make this requirement to minimize the possibility of a death or disability claim soon after the employee is covered. Dependents also are supposed to be in good health when their coverage begins, but usually they do not have to provide medical evidence.

The medical evidence requirement usually does not affect groups in which more than 35 to 50 lives are covered. Usually insurers do require a statement of health from each employee in a group of less than 10. Other factors such as the amount of risk and age of the employee may be considered. Potential problems may limit or exclude benefits, as in the case of an employee with a history of lower back problems. He might be rejected for long term disability coverage. Because of the expense involved, medical examinations are usually not called for except in unusual circumstances. An insurer might require a physical exam only for employees 50 or older who are to have more than $50,000 of group term life coverage. Section 79 of the Internal Revenue Code restricts the use of medical exams in cases covering less than 10 lives. Such a requirement could cause loss of tax advantages.

When the determination has once been made that the employee is insurable, there can be no change in that decision unless there is proof of intent to defraud. Deterioration in the health of an individual after his coverage begins cannot affect his status.

Medical insurance audit bureaus usually include the medical questionnaire completed by the employee in his portfolio. These portfolios, known as MIBs, may be referred to by insurers in underwriting high-risk cases.

**Pre-Existing Conditions**: In an effort to keep from having to pay excessive benefits for a disability incurred before the effective date of the coverage, insurers have introduced the pre-existing conditions clause. This clause typically limits an insurer's liability for benefits paid within three, six, or possibly twelve months of the effective date of the coverage if the insured received treatment for the disability within three months prior to the effective date of the contract. If an employee became covered on June 1 and his wife had received treatment for a kidney ailment on May 1, the benefits payable for her treatments for the same ailment would be limited for the period specified in the contract, such as six months. The limits might be in a dollar amount, such as that the plan would pay not more than $1,000 for such treatment during that period, or there might be a major medical exclusion under which base plan expenses would be paid but supplementary major medical expenses would be excluded during the six-month period.

Under a group insurance plan, the employer enters a contract with an insurance company to which he pays premiums. The insurance company provides health and disability benefits for the employee and his family, and pays death benefits to the family if the employee dies.

Premiums paid are tax deductible to the employer when plans are constructed in accordance with IRS guidelines. Health and disability benefits, under the same conditions, are not taxable to the employee. Death proceeds are not taxable to the beneficiary.

Coverage purchased by individuals for themselves would require much higher premiums than a group policy. The only other alternative for providing coverage to employees is self-insurance administered by the company. In this system the company, because of the relatively small size of the group, cannot estimate with any certainty how much money will have to be paid out in benefits or claims over a certain period of time. Also the company itself has to do the work of administering the program.

With group insurance the cost is locked in for a stipulated period of time, and the insurance carrier normally does most of the administrative work. A self- insured plan also may not meet the requirements for tax deductibility of premiums if benefits are not equal for all employees.

To produce a proposal for group insurance coverage, the agent fills out a census data form giving the names and genders of employees, their dates of birth, annual incomes, names of dependents and whether or not they are to be covered, benefit levels or formulas desired, and the employer's contribution.

If the policy is to replace a previous one, the needed information includes a copy of the employer's most recent group insurance billing statement, a copy of the current group insurance plan booklet, and the claim experience for the past year if the group has 25 or more members. This information is used to tailor a proposed policy to suit the group's needs.

The company is the applicant and owner of the policy. Premiums usually are split between employer and employees. Beneficiaries are named by the insured.

The employer who has a good group plan turns administrative and tax problems over to the insurance company, which has a professional staff to cope with such matters. The employer's expenses for doing so are tax-deductible.

**Future Possibilities**

In addition to the standard group insurance coverage for life, health, accidental death and dismemberment, basic medical, major medical, comprehensive medical, and disability income, new fields are opening up. Group dental insurance has been rapidly gaining in popularity. Newer introductions include vision care, prepaid legal, and group auto insurance. If the trend of group insurance growth continues, these may offer major opportunities in the future. Most employee benefit plans start with basic coverage and add more benefits as time goes on. It is up to the agent to help the business prospect determine whether or not he has adequate coverage.

**Group Long-Term Care Insurance**

Group long-term care insurance defined- "Group insurance" is generally defined as an insurance contract made with an entity such as an employer, professional, or trade organization. It covers the people who have a relationship with the entity (employees, union members, etc.) purchasing the contract as well as their families/dependents. Premium payments may be split or paid by one side or the other. This type of insurance is typically written for life, health/accident/ annuities, and disability.

Long-term care insurance is a type of coverage that is rapidly growing in importance. This type of insurance pays a daily or monthly benefit for medical or custodial care received in a nursing facility, or at home. Two of every five persons over age 65 will spend some time in a nursing home. At any given time, one per cent of those aged 65-74 resides in a nursing home. That proportion increases to seven per cent for those aged 75-84, and to more than 20 per cent for those aged 85 and older.[1]

The cost of long-term care is staggering. Nursing facilities charge more for one year's stay than most Americans earn during their peak earning years. Medicare provides only limited assistance since only skilled care is covered, up to a maximum of 100 days in a benefit period. Custodial care is excluded altogether. The Medi-Cal program may cover long-term care if an aged person is poor and can meet a stringent means test. We will cover this in a subsequent chapter. To many people, coverage under a welfare program is not likely to be a satisfactory solution.

**Vision Care Insurance**

Although this coverage appeared much later than dental insurance, it is growing in popularity. It typically has deductible and coinsurance provisions like those of dental insurance. Usually the coverage is limited to scheduled maximum benefits. Eye examinations, glasses, and contact lenses may or may not qualify for full benefits. Vision care coverage usually is added to a group health insurance policy rather than being issued separately.

**Prepaid Legal Coverage**

Growing interest in prepaid legal services provided through group insurance resulted when amounts contributed by employers to a "qualified group legal services plan" were held by the IRS to be tax-exempt to employees. Benefits are for non-business legal services. They may pay all or part of legal fees for the insured. The plan must not discriminate in favor of officers, highly paid employees, shareholders, or the

[1] *Meeting the Need for Long-Term Care,* E. Graves and B. Beam, Jr., (Bryn Mawr, Pa; American College, 1989)

self-employed. The IRS must be notified officially to qualify the plan for the tax-free benefits.

**Auto Coverage**
Although state laws and company requirements may vary, group auto insurance appears to be a growing field. One plan provides for the employer to pay at least 50% of the cost and the balance to be handled through payroll deductions. When an employee retires or leaves the job a conversion auto policy is available.

Rates may be the same per car regardless of the type of vehicle. Policies are experience-rated on an annual basis. Benefits may include bodily injury and property damage liability, medical payments, no-fault personal injury, comprehensive, collision, towing and labor, and uninsured motorist protection.

While these newer forms of group insurance may take time to become widely accepted, the continuing trend toward group coverage shows no sign of slowing down. The agent who wants to be successful in the insurance profession cannot afford to overlook the opportunities in the field of group insurance.

**Underwriting New Business**
It is difficult for an insurance company to correct problems with a group once it is covered by a policy. These problems may have been overlooked when the policy was written, or they may have arisen since. In any case, it is very important for the initial underwriting of a new or takeover group to be done in the most careful manner possible. Underwriters may seem to have an excessively hard-nosed attitude about new groups, but it is to the employer's advantage to be insured by a carrier which is careful about screening new business in order to avoid bad risks. Because small group insurance business is usually pooled, excessive claims from some members of the pool can affect the premiums of all employers in the pool.

The insurer may turn down a group which has a large number of seasonal employees or a high turnover rate. In some cases a group in which more than one-third of the employees are 60 or older will not be accepted for coverage. Small companies in which relatives of the owner are employed are given careful scrutiny. One carrier, for instance, has a rule against taking on companies in which the owner and his family members make up more than half of the eligible employees. Another insurer goes by an informal rule that if its proposed rate is less than 75% of that of the previous carrier, it is probable that not everything about the case has been disclosed. Grapevine information that a company is frequently looking for a new carrier may help identify a bad risk.

When a takeover case is accepted, the waiting period usually is waived for employees and dependents covered under the former group plan. Employees, however, must meet the eligibility requirements for coverage just as if the case had not been transferred. Therefore an employee who rejected coverage under the old plan would in most cases be required to furnish medical evidence in order to be covered under the new plan.

In the case of small groups being taken over, the requirement that satisfactory evidence of insurability must be furnished by the employee for life coverage in excess of guaranteed issue amounts usually is not waived. This may work to the disadvantage of a member of management personnel of a small company who has become uninsurable since the first group policy was established.

**Transfer of Coverage**
Under what is called a "no loss-no gain" type of provision, a new insurer often agrees to cover an employee who is not actively at work or a dependent who is hospitalized at the time group coverage is transferred from the previous carrier. The coverage will be only up to the limits of the previous plan, and payments made by the new carrier are reduced by the amount paid by the previous carrier. It is common for pre-existing conditions clauses to be waived in the case of transfer business or if a "no loss-no gain" type of provision is involved.

**Definitions Retained**
In takeover situations the definition of "employee" and "dependent" is essentially unchanged, and underwriting rules applying to new employees and dependents are applicable in the new or takeover case, with a few exceptions.

When a master contract is terminated, liability for a permanently disabled dependent child over the age of 18 may cease. In this case the child who cannot support himself because of disability probably will not be covered under the new contract unless a special provision is applied.

Also on termination of a master contract, group term life coverage for a disabled employee provided under a waiver of premium provision might not be continued. The new carrier, however, often will accept the liability for the disabled life coverage at additional cost.

**Weighing Risks**

Some companies studying prospective takeover cases may review the experience of a prior carrier for almost any size group. It is felt by most actuaries, however, that the prior experience of a group of fewer than 35 lives is not completely valid because at least 200 life/years of experience need to be involved to give a meaningful determination of a bad risk.

Insurers do know from experience, however, that employers in some industries are better risks than those in others. Not only businesses which have a high potential for death or illness are discouraged by loaded rates and limited coverage, but also those with a high turnover of employees or a high rate of business mortality. Most insurers believe they have to cover a risk for at least two years to make a profit on the business, so they are not eager to underwrite a business in a field with severe financial problems.

**Rules on Participation**

If only a few individuals in a group joined an insurance plan, there would be selection against the carrier. For that reason insurers have always insisted on participation rules, and tax laws have reinforced those rules. The requirements for participation as they traditionally have been set are now more complicated under the most recent revisions of the IRS code. Basic requirements deal with number of lives to be covered, number of employees covered, dependent coverage, and contributions required.

**Number of Lives Covered:** Most standard group policies have been designed for a certain number of lives. If the package covers three to nine lives and the group falls to less than three, coverage will be terminated. This may be required under state regulations as well as insurance company policy. The upper limit is not so strictly watched, but an eligible employer will find more flexibility in larger package plans if he has them available.

**Number of Employees:** Ordinarily carriers require that at least 75% of the employees of a firm participate in the group insurance program. For groups of under 10, the requirement is usually higher. If there were only three employees, all would have to be covered.

**Dependent Coverage**: There are similar participation rules for coverage of dependents. The usual requirement is for 75% of the dependent units, for instance 75% of all families, to participate.

The level of employee contribution requirements can affect participation in the plan. Carriers usually set a maximum and encourage lower employee contributions because they know the smarter young employees may prefer to buy their own coverage if contributions are set too high, thus raising the overall cost of the group. A noncontributory plan also may have problems. Insurers usually require all eligible employees in a small noncontributory plan to be covered, to guard against the possibility that the employer might wish to purchase group coverage for himself and purposely overlook covering some of his employees.

**Required Contributions**: Employer contributions are required for group term life coverage and usually for other types. Sometimes better premium rates are given to plans which are noncontributory. An insurer often will specify that maximum employee contributions cannot exceed 75% of the cost of all coverage. A carrier may also require a maximum employee contribution of either 60% of the cost of all non-life benefits or 100% of dependent coverage.

## Commonly Used Group Insurance Terms

**Accident and health insurance**: Policies that in general pay benefits in case of illness, accidental injury, or accidental death.

**Adverse selection:** Also known as anti-selection, this is selection against the insurance company resulting

from the tendency of poor risks, such as persons in bad health, to be more likely to seek insurance or to continue insurance than other persons.

**Anniversary Date:** The time one year or more after the effective date of a group policy when renewal of the master contract is due.

**Annually Renewable Term:** This (ART) is the type of group life insurance usually written, renewable yearly at a rate recalculated each year on a basis of the new ages of participants. The rate can be affected by employee turnover and can vary up or down from year to year. This type of policy is also known as Yearly Renewable Term (YRT).

**Assignment**: In health insurance, the signing over of benefit payments to a hospital or other provider of medical care. In general, assignment is a provision regarding transfer of an insured's rights. In life insurance it refers to conveying the benefits to a third party. The insurance company does not guarantee the validity of an assignment.

**Benefit Period**: The maximum length of time for which benefits will be paid under health insurance in the case of any one accident, illness, hospital stay, or disability.

**Blanket Insurance:** A policy covering a number of individuals exposed to the same risks, such as campers, athletic team members, or similar groups.

**Brokerage Business**: The cases received by a company from insurance brokers, or from agents of another company.

**Calendar Plan**: A health coverage plan with a deductible applied once during a given year, and which also may have a maximum benefit sum to be paid within a calendar year.

**Census Data**: Information collected in group policy writing. The policy is underwritten and rates set on the basis of the people who make up the group, so the underwriter must have a complete census of the individuals in the group. Specific forms to be filled out for all employees to be enrolled in a group plan are provided by most insurance companies. They ask for the full name, date of birth, sex, dependents, and other pertinent information about the employee.

**Certificate**: A document specifying essential features of the coverage provided by a group policy, issued to the policy holder for distribution to the persons insured under the policy. The certificate may be printed in a booklet providing additional information about the group coverage.

**Classes**: Divisions of coverage levels. Larger benefits under life and disability group insurance usually are provided for more highly paid employees than for others at lower pay levels.

**Community rating**: Basing costs on the general experience and cost level for a certain geographical area. Now rarely used in group insurance, in which carriers usually rate by individual case experience or by pools of small groups not necessarily rated by location.

**Composite rates**: Result of combination of different rates to arrive at an average.

**Comprehensive major medical insurance:**
Coverage providing both basic medical and major medical protection, with a low deductible amount, high maximum benefits, and a coinsurance clause.

**Contributory**: A term describing a group insurance plan in which those insured pay part of the premium. The opposite is a noncontributory plan, in which the total premium is paid by the employer.

**Convalescent Care**: Care in a facility specializing in extended treatment rather than in-hospital care.

**Conversion clause**: Provision that group life insurance lost on termination of employment be convertible into individual policies without evidence of insurability. Such a clause is generally required under state law.

The premium for the converted policy is determined by the attained age of the insured. Some states also require group health policies to have conversion provisions.

**Coordination**: A provision allowing a combined full recovery of benefits when both a worker and spouse are covered by different group plans. Neither plan pays full reimbursement but the two together do, with the disabled person's own plan paying first.

**Cutbacks**: In group life insurance, a reduction in coverage for an insured at a specified age, usually at retirement, in order to keep life insurance coverage costs within practicable limits. The cutback usually is a specified percentage reduction in the face amount of insurance annually beginning at age 65 and continuing until the coverage reaches a minimum amount.

**Dependent Life**: Life insurance on the spouse and children of a person covered under a group policy. It is issued in fractional amounts and in states with statutes relating to this coverage, is a severely limited, benefit amount being fixed by law.

**Disclosure**: Filing and annual reporting of employee benefit programs with the U.S. Department of Labor, required by ERISA, the Employee Retirement Income Security Act. Some states also have disclosure laws with similar requirements.

**Emergency accident**: A benefit, not subject to a deductible, providing for outpatient coverage for treatment given within 90 days of an accident.

**Employee benefit program**: An arrangement under which an employer offers employees insurance coverage for medical expenses, disability income, retirement, death, and sometimes other items such as legal expenses, with the employer paying the cost of the coverage in whole or in part. These benefits are separate from wages and salaries and thus are usually referred to as "fringe benefits."

**Exclusions**: Limitations on the scope of coverage by provisions excluding certain risks, such as war losses or some types of aviation risks. Every insurance contract contains exclusions, which should be pointed out to the buyer.

**Experience rating**: Process of reviewing the claims history of a group policy in order to set a premium for the next period. The ratio between claims and premiums increases in validity with the size of the group.

**Flat Deductible**: The amount of covered expenses payable by the insured in a health policy before benefits under the policy are payable.

**Fringe Benefits**: General term for benefits other than salary or wages, provided by employers for employees under formal or informal arrangements.

**Group:** In insurance, a number of people who have some common factor such as occupation, place of employment, membership in an association, or other element in common.

**Group ordinary life**: Ordinary level premium life insurance issued to cover a group of individuals.

**Group permanent life insurance**: Level premium life policies with cash values and paid-up values, issued on a group basis.

**Group sales representative**: A person who promotes, sells, and installs group insurance plans, usually a salaried person operating in a specified geographical area.

**Hospital miscellaneous:** Charges made by a hospital in addition to those for room and board, including operating room fee, laboratory services, drugs, dressings, anesthesia, and other charges, though not including on a reimbursable basis items such as TV and telephone billed by the hospital.

**Incurred claims**: Claims resulting from events which have already occurred but have not been recorded by the carrier because they were not reported or because records were lost or misplaced.

**Indemnity policy**: Under indemnity, a policy pays a specified amount when certain conditions are met rather than reimbursing an insured person for expenses. Indemnity contracts include life insurance, accidental death and dismemberment, and disability income plans.

**Inspection reports:** Investigation results reported by a commercial inspection agency employed by an insurance company to check the finances, stability, and apparent health in case of a group prospect, and sometimes in the underwriting of individual policies. In group insurance such investigations are considered especially important in underwriting small groups.

**Insurance age**: In insurance underwriting, a person's age is considered as changing six months after his or her last birthday. This is true for both group and individual insurance and is the reason for requiring the date of birth rather than the year of birth on group enrollment documents.

**Late Entrance**: An employee who decides to apply for coverage in a group insurance plan after declining to enroll initially.

**Limitations**: Elements of insurance contracts helping to define the limits of coverage included in all group insurance contracts. Limitations are designed to prevent abuses and hold down premium costs, and need to be explained carefully to the policy holder and the individuals insured. A group term life policy, for example, gives employees no assurance that it will be continued so it does not replace the need for permanent coverage.

**Master policy or contract**: Document issued to the employer or other sponsor containing all insuring clauses defining terms and benefits to be paid under a group insurance plan. Individuals participating in the group plan receive certificates summarizing conditions and benefits of the master policy.

**Model bill**: Guideline for state legislation regarding group insurance drawn up by the National Association of Insurance Commissioners. Some states have adopted such legislation, either unchanged or with modifications. Other states have not.

**Multiple employer trust (MET)**: A trust formed by companies banding together to offer employee group benefits in an effort to obtain coverage rates for each participating firm lower than they could expect with separate group policies.

**No loss-no gain:** An agreement when a new carrier takes over a group plan that benefits as provided under the previous carrier's plan will not be lowered by the change-over.

**Package**: Method of marketing group insurance to smaller firms by offering certain fixed combinations of benefits. This practice enables the carrier to cut costs by standardizing the underwriting and preparation of contracts as well as forms for enrollment, billings, and claim settlements.

**Per cause**: Term referring in major medical policies to the basis on which a deductible is figured or on which the maximum benefit is applied. In this arrangement, as opposed to the calendar approach, each separate cause could require a separate deductible and provide the insured with a separate maximum benefit regardless of the time at which the loss occurred.

**Pooling**: Putting small risks together and evaluating the entire pool in setting risks. This gives sufficient mass in the underwriting to make spreading of risks possible, according to the basic principle of insurance, although it may mean that small groups with few or no claims in effect subsidize those with large claims.

**Plan Administrator**: Person who is appointed by the employer or sponsor to administer a group insurance plan for the company or sponsoring organization. This person is responsible for handing many of the administrative details in connection with the plan and is a key contact for the insurer.

**Rehabilitation:** Provision under which a claimant receiving benefits under a long-term disability (LTD) plan may continue to receive at least partial payments while being retrained and looking for new employment.

**Reserves**: Funds an insurance company is required by law to maintain for adequate coverage of risks. In group insurance the term usually is used in connection with the year-end analysis of the pool or individual company risk before premiums for the coming year are decided on. In addition to the legal reserves, the insurance company has to have amounts on hand for incurred but as yet unknown claims as well as reserves for maternity and major medical coverage.

**Retired lives reserve**: An employee benefit under Section 79 of the Internal Revenue Code through which an employer can use tax-deductible dollars to pre-fund the cost of providing post-retirement life insurance for all or some of its employees. Contributions are made by the employer to a reserve fund which is used to continue premium payments on an individual's life insurance after a stated retirement age. Both pre-retirement and post- retirement life insurance may be provided under the plan.

**Section 79 plan**: A combination of group term and permanent life insurance authorized under Section 79 of the Internal Revenue Code. Premiums are ordinarily paid by the employer and when the plan is properly structured they are fully tax deductible for him. The employees have to report as gross income only the cost of the "permanent benefit."

**Self-insurance**: Commitment by an individual or business to pay claims under a group benefit arrangement without having formal insurance. Some plans may be self-insured up to a certain level and then have an insurance policy effective above that level.

**Social Security**: Programs provided under the Social Security Act of 1935 and later amendments. These now include Medicare as well as Old Age, Survivors, and Disability Insurance.

**Statement of health**: A form asking specific questions about recent medical treatment used to establish insurability of an applicant who did not enroll in a group insurance plan when first eligible, or who is re-enrolling. The form gives the insurance company authorization to check for further information from doctors or hospitals.

**Statutory disability plans**: Disability laws in several states, including California, Hawaii, New Jersey, New York, and Rhode Island, require employers to provide weekly indemnity payments for off-the-job injuries and illnesses. The insurance agent in an area with such requirements needs to be aware of them.

**Stop-loss provisions:** A specific charge may be paid by a policy holder in group insurance to assure that losses exceeding a set figure will not be charged against his claims experience. This is a provision to minimize fluctuations in claims experience and an insurance company's charge for carrying the risk.

**Transferred business**: Group insurance that has been moved from one carrier to another.

**True group**: In contrast to franchise or wholesale group insurance in which individual policies are issued to participants, "true group" refers to that issued under a master contract. Certificates of insurance which, not policy contracts are issued to the individual insureds. The policy is held in the name of the group being insured by the company, worker's group, or organization offering coverage.

**Trust agreement**: Legal instrument under which a trustee operates in dealing with the insurance company and administering a group insurance plan, either for one employer or several units.

**Uniform Premium Table**: An Internal Revenue Service table which standardizes the taxability of group term life insurance premium costs when applicable. It is also known as Table 1.

**Waiting Period**: A period on the job specified before new employees become eligible to enroll in a group insurance plan, often set as 30 days. Another type of waiting period, in disability income insurance, is the length of time between the beginning of the disability and the start of the period for benefits to be payable.

**Waiver form**: Proof when signed by an eligible employee that he or she received information about a group plan and chose not to enroll.

**Yearly renewal term (YRT):** See Annually Renewable Term.

**Group Life Insurance**
Life insurance coverage is provided to employees in most cases through an annual term life policy with no cash values. Premiums paid can be based on the average age of the group, the experience rate of the employer's industry, the employer's actual experience rate, and other expenses.

Group life insurance provides coverage for those who might otherwise be uninsurable. It provides peace of mind for those who already have personal life insurance and savings by giving added protection for the individual and his family.

Group term life insurance plans have their limitations. Employees with group coverage may feel that they have adequate protection for their needs when they do not. In large group life plans the employee is not afforded the personalized service given when an individual policy is purchased. Often the employee has no one with whom to discuss the family cash requirements, and thus could get a false sense of security.

Employees can inform themselves by reading their group insurance booklets and asking questions in order to adequately prepare for possible untimely death. The agent can help coordinate the employer's efforts in communicating important insurance information.

**Changes Possible**
Group insurance policies are experience rated from time to time by insurers on the basis of claims and expense experience, and premiums may be adjusted if necessary. Usually group term life policies are up for renewal annually, although some may be guaranteed for longer periods, from two to five years.

Insured employees should understand that they have no guarantee that group coverage will be continued from one year to the next, because the employer may decide to discontinue or change the policy, and there are no cash values with term insurance.

When an employee loses his job, he loses his group insurance. He has a chance to use the conversion privilege, but in actual experience relatively few people do so. Also, group insurance protection usually ends or is greatly reduced at retirement. A group life insurance plan should not be confused with an adequate personal savings and protection plan.

**How a Group Life Insurance Plan Functions**
With group life insurance all employees enrolled in the program are covered under one policy. It is not necessary to issue a separate one to each individual. The group life insurance contract is known as the "master policy".

The contractual relationship between the policy holder and the insurance company is outlined in detail in the master policy. Individuals insured under the policy are issued certificates of insurance giving information on benefits and claim procedures.

Often an announcement booklet accompanies the individual certificate, explaining the employee's coverage and the dependents' coverage if provided for. The booklet will include eligibility requirements, how to join the plan, when the coverage becomes effective, employee benefit amounts, tax laws involved, how benefits are paid, beneficiary designation rules, assignability, claims procedure, conversion features, and other general plan information.

Also required to be stated are the employee's rights under the Employee Retirement Income Security Act.
If the business installing the group plan is a corporation, in addition to the master policy there must be a formally drafted resolution detailing the eligibility requirements for employees, amounts of coverage, retirement and disability provisions, and other details. The resolutions must be passed by the board of directors of the corporation offering the group plan.

**Eligibility Requirements**
To be a qualified group life program the program benefits must be made available to all the employees or a majority of them as set out by the IRS. The time at which an employee becomes eligible for coverage can vary with the different policies and groups. At the inception of the plan usually all actively employed persons

considered "regular, full-time employees" are offered the plan.

After the inception of the policy when new employees come on board, if all employee eligibility requirements are the same there will usually be a waiting period before the employee qualifies to join the plan. The waiting period is usually 30 to 90 days, but it may be longer.

In some plans new employees will be designated as exempted from the probationary time, and others will be designated as non-exempt. The exempt employee is eligible to become a member of the group life plan on the date of employment as a regular full-time employee. The non-exempt employee is eligible to become a member on the date of completion of a stated amount of continuous employment as a regular, full-time employee. The insurance booklet usually contains a specific definition of what the plan considers a "regular, full- time employee."

If coverage for dependents is offered in the plan, they usually are eligible on the day the employee is eligible. Each plan will stipulate what is considered a dependent, i.e., spouse and children below a certain age. The plan may also state guidelines for dependent coverage if both parents are employed by the same company, or if the dependent is employed by the parent's company.

**Joining the Plan**
After the probationary period, there is an enrollment period during which the new employees must submit an insurance application in order to join the group life insurance plan. If they do not submit their application within the stipulated period, usually 31 days, and make application later they are can be required to submit evidence of insurability before enrollment is allowed. Some plans will bar the employee from enrollment until the next "open enrollment" period, which usually is held annually.

If the employee's premiums are paid 100 per cent by the employer, formal enrollment is not required, but the employee must submit a Group Life Beneficiary Designation. If the employee elects coverage of dependents, a formal enrollment application must be made and submitted within the 31-day time limit.

**When Coverage Becomes Effective** Group policies require that the employee's coverage begin on the date of eligibility if the employee is then actively at work, otherwise on the day the employee returns to active work. If dependents have been enrolled for coverage, the dependent coverage will become effective on the date the person becomes a dependent or the date or the employee's effective date, whichever is later.

**How Dependent Coverage Is Added Or Cancelled**
If the employee already has dependent children coverage, any child born thereafter will be covered automatically by the plan. New coverage for the first dependent child requires in most cases that the employee complete a new enrollment card within 31 days of the date of birth.
The same rules usually apply for new spouses to be covered by the plan. If the employee becomes divorced from the covered dependent or the dependent child reaches any age limits imposed, the employee must complete a new enrollment card.

**Open Enrollment**
Once a year the company management or board will take a look at the current group56life insurance plan and decide if it is satisfactory or if another plan is desirable. Even if the same plan with the same benefit levels is desired, the process of attaining a new master policy and enrolling the "regular, full-time employees" into the plan must be repeated.

As mentioned, the master policy is usually a one year coverage contract. Accordingly, a new contract must be entered into each year as the old contract expires. After the new agreement has been entered into, the company will again have "open enrollment" for all eligible employees. If the employee fails to enroll in the plan or fails to enroll the dependents in the plan during this 31-day "open enrollment" the employee could have a year to wait until the next "open enrollment," or have to prove insurability to join the plan. Some plans do have contract periods from two to five years, but the vast majority of group life insurance plans offer only 12 months of coverage.

**Employee Benefit Amounts Benefits** can be determined in various ways. The master policy will include a

predetermined schedule of benefits as will the employee insurance booklet.

One of the most common methods of determining benefits is the flat rate method. Each employee's beneficiary in this case would receive the same amount of predetermined death benefits. All job classifications in the company would receive the same coverage.

The beneficiary might receive a benefit calculated using a multiple of the employee's earnings at a specified time during the policy period. For example, all employees would receive two times base annual salary.

The maximum amount of coverage in the plan would be $700,000. Base salary is the salary of the employee as of October 1 and does not include bonuses, commissions, overtime pay, shift differential, or any other extra compensation. For example, an employee with an annual base salary of $15,000 would receive insurance coverage in the amount of $30,000. One making $20,000 would receive $40,000 in insurance, and one with a $25,000 base salary $50,000.

The group life coverage may be based on an occupational classification method. For example, officers of the company might receive $50,000 in insurance coverage, supervisory personnel $40,000, and support personnel $35,000.

The group life coverage also can be a combination of these methods. Commissioned employees might receive $40,000 in coverage and all others two times base annual salary, not to exceed $700,000.

The amount of coverage that will be offered the employees is determined by the business owner or the board of directors, before the inception of the policy.

The plan will state whether the employee is eligible for increased coverage through the year if there is a change in salary. Most plans lock in the benefits the employee is entitled to for a specific amount of time and they are not subject to change until that time has expired.

**Dependent Benefit Amounts**
If the plan provides for dependent benefit coverage the group life insurance master policy and employee insurance booklets will include a short paragraph on the benefits. The information will include the amount of coverage available for the dependent spouse, and the usually lesser amount available for the dependent children if so offered.

**Cost of the Plan**
A group life insurance plan can be paid for exclusively by the employer, or can be split between the employer and employee in a predetermined ratio. It is not uncommon for a plan to be 100 per cent funded by the employer. Group term insurance provides a means of solving for employers the problem of taking care of survivors if an employee dies.

By contributing to employee morale, the plan gives the employer a competitive edge in hiring well qualified new employees and retaining old ones. Because it provides a benefit which employees otherwise would need to purchase with after-tax dollars, it can ease the pressure of demands for salary increases. It improves the company's public image and helps prevent further government encroachment into the business world.

Of course the biggest advantage is that each dollar spent by the employer on the employee is tax deductible to the employer if the program is qualified by the IRS. In order to be qualified benefits must be offered on an equitable basis to employees.

**Additional Coverage Costs**
Under some arrangements an employee may have additional coverage over those in the basic group policy by making a contribution to the premium. The additional amount is not usually considered a part of the master policy but is offered as a part of the employee perk package. Even in this case the cost of the premiums to the employee is much less than it would be if the employee had an individual policy.

**Tax Ramifications to the Employer**
If a group life insurance plan is structured properly, the premiums paid for the coverage by the employer on behalf of the employee should be tax deductible to the employer. The tax rules and regulations covering group life insurance have been stiffened to insure that group life plans take care of the groups they are intended to care for.

For example, the employer cannot be named as an employee's beneficiary and retain tax favor on the group plan. Group life policies in most cases give the employee who joins the plan the right to name and change a beneficiary as he wishes. A limitation is that the employer may not be named as a beneficiary without affecting the tax status of the plan.

If an employer were allowed to be named beneficiary, the initial group life plan to assist the employees could be maneuvered into a key employee plan designed to assist the business owners. The group life plan is not taxable to the employer because of the help it gives the employees. The key man plan is taxable to the employer since it has nothing to do with helping the employees, but helps the employer.

In a key employee plan the employer insures the life of certain employees to safeguard the financial status of the business if a key person were to die. By being the named beneficiary of an employee on a group life insurance policy, the employer would receive the death benefit to assist the business while a new key person was found and trained. The survivors of the deceased do not benefit. Therefore, if the employer company is the named beneficiary the group plan would lose its tax position in the eyes of the law.

**Qualified Group Size**
There is no 'minimum' size for group insurance coverage. A small group is generally defined as one who employs at least 2 people. The law in several states defines an eligible employee as one who works on a permanent basis and has a normal work week of 30 or more hours. This includes a sole proprietor, or a business owner. The term does not include an employee who works on a temporary or substitute basis or fewer than 30 hours a week.

On January 1st, 2016, the ACA changed the way it defines 'Small Group Employer.' If a business has 51-100 employees, it will be reclassified from a 'Large Group Employer' (defined as 51+ employees before) to a 'Small Group Employer' (defined as 1-100 employees, after 01/01/16). Employers with 101+ employees will continue to be classified as a 'Large Group Employer.'

Group term life premiums paid by an employer on employees are deductible if the insured employee's compensation level overall is reasonable, and if the employer is in no way a beneficiary of the insurance. Premiums paid by the employer are not counted as taxable income to the employee if the insurance coverage is $50,000 or less. Any coverage over $50,000 provided by the employer is taxable income to the employee.

For a plan to be qualified for tax favor by the IRS, all qualified full-time employees must be provided insurance. The insurance must be provided whether or not the employees are required to obtain evidence of insurability.

The insurance company decides if evidence of insurability is required for their plan. It may or may not be required. If required, it is limited to a medical questionnaire completed by the employee. No physical examination is involved. Employees who have not completed a specified probationary period, which may not be more than six months, or who work part time need not be included in a group life insurance plan. To qualify for tax favor the group life plan must provide protection by one of the following methods:

- A uniform percentage of employee compensation
- An amount set by coverage brackets which the insurer establishes

For instance, company officers might have $50,000 in insurance coverage, department heads $35,000, salesmen and supervisors $25,000, and other employees $10,000. The general rule is that no bracket may be more than two and a half times the next lower bracket, and the lowest bracket must be at least 10 per cent of the highest bracket.

Under either method the amount computed may be reduced for employees who do not provide satisfactory

evidence of insurability without disqualification of the plan by the IRS. Employees over 65 may have a separate schedule of coverage established under similar guidelines.

**For Small Group Plans**
It is also possible to provide a group plan to small groups. Care must be taken by the employer and underwriter so that;

- Evidence of insurability is not required and does not affect the amount of insurance offered to any employee
- The insurance is available under a common plan to employees of two or more related employers
- The insurance is restricted to employees who belong to an organization such as a union that carries on other substantial activities in behalf of the employer, and the insurance is mandatory for those employees.

If all the criteria for a qualified plan as stated are met by the small group plan, the premiums paid by the employer are deductible by the employer, and are not considered taxable income to the employee.

**Tax Ramifications to the Employees**
As stated before, any coverage of $50,000 or less provided by the employer is not taxable to the employee as additional income. Any coverage over $50,000 provided by the employer is taxable to the employee as additional income as determined by the IRS' tables. Any premiums paid by the employee for group coverage or for additional life coverage cannot be taken as a deduction on the employee's federal income tax return.

**Tax Ramifications to the Deceased Employee's Estate**
For estate tax purposes, proceeds of death benefits will be included in a deceased employee's gross estate if there are any incidents of ownership. Incidents of ownership include;

1.) Right to name or change the beneficiary
2.) Right to assign the policy
3.) Right to convert the policy.

If the employee's rights to the group policy are assigned, and the employee dies within three years of the assignment date, the death benefits are subject to estate taxes. Under current federal tax laws, only very large estates are affected by these taxes, but state death taxes remain a consideration.

**Death Benefit Tax Ramifications to the Beneficiary**
A lump-sum payment of group term insurance death benefits to an employee's beneficiary is exempt from income taxes just as an individual policy benefits are.

There are other ways in which payment of death benefits can be made if the plan so provides. They include the annuity method and the installment method. The percentage of the benefit payment that represents a payment of the policy face amount (lump-sum amount) is not subject to federal income tax. Each payment will represent a portion of interest earned and a portion of face-amount payment. Tables have been developed to calculate the taxable interest earned portion of the payment and the nontaxable amount of the payment.

**Coverage after Employment Termination**
Naturally there is a turnover in employees for any business. Group policies have special provisions affecting individuals who leave a company which is covered with a group life insurance policy.

Group life insurance may be converted into an individual policy by the employee who leaves. An individual converting into an individual policy usually does not have to provide evidence of insurability. The individual's age will determine the rate of premiums required on the new individual policy.

A former employee usually has 31 days to convert group term life insurance coverage into an individual policy without submitting evidence of insurability. If an employee dies within the first 31 days of severance from the covered employer, the death benefit is still payable under the group life insurance policy of the former employer. This extension of benefits gives protection while the insured is considering whether to convert to an individual policy or whether to be covered under the group policy of a new employer.

**Termination of Employment Through Retirement**
Under most small group contracts, the coverage of an employee is terminated when he retires. There are some group life insurance products that allow the retiree to convert to an individual policy. Commonly, the converted policy face amount is reduced substantially after retirement.

**Termination of Employment Through Death**
If the plan provides for coverage of a dependent spouse, and the employee dies, the surviving spouse usually has the same rights to convert coverage as the employee had. Covered children may or may not have these rights. Usually if so they will be eligible for a lesser amount of insurance in a converted policy.

**Termination of Employment Through Disability**
Another factor usually included in group life policy provisions is a "waiver of premium" for group members who become totally and continuously disabled before a specified age. If an employee becomes disabled, the applicable premium for that employee/insured is waived by the insurer, and the employee's full coverage is in force for the policy stipulated time period.

**Claims Procedure**
In the master policy for the group life insurance plan, standards for paying claims will be established. The employee insurance booklet will state the procedure for making a claim, what documents are needed in making a claim, and where a claim should be sent.

Also included is a statement of the system that will be employed if the claim should be denied, and what the beneficiary's rights and recourse would be in such a case.

**Permanent Life Group Plans**
Some group life insurance plans have been developed which provide a measure of permanent protection. The Level-Premium Group Permanent Plan offers level premiums payable either for life or to age 65 for a policy which at time of retirement gives the insured employee paid-up options. This plan is now used mainly for funding pension benefits, because under an IRS ruling premiums paid by an employer under such a plan are otherwise taxable to the employee.

**Section 79 Plans**
A plan offering a combination of group term and permanent insurance qualifies for favorable tax treatment under Section 79 of the Internal Revenue Code. A flexible arrangement, the Section 79 plan may offer both term and permanent life insurance under a master contract, as separate policies or as a combination. It also may be added to an existing plan of group term life insurance covering a group of employees. Permanent protection can be continued for a retired employee. The death benefit remains constant.

Cash values in a Section 79 plan accumulate tax free, as in any permanent insurance policy. They belong to the employee and may be borrowed, used as collateral, or otherwise treated like those in any individual cash-value policy. If the employee leaves the firm before retiring, he can take over the premium payments and continue the insurance protection under the Section 79 plan.

While a master contract for a group term plan can be cancelled by the insurance company if the experience rating shows it is too costly, the individual policies in a Section 79 plan cannot be cancelled and the premium cannot be increased.

It is possible to add supplementary benefits such as premium waiver in case of disability or accidental death benefits to a Section 79 plan, with the premium cost of the supplementary benefits deductible to the employer and not chargeable as income to the employee. If an occupational classification or health problem on the part of a covered employee makes an additional premium necessary, that amount is deductible by the employer and tax-free to the employee.

Cash value accumulation in a Section 79 plan can help build retirement income. On the group term insurance part of the plan, if the employer continues paying premiums after the employee retires, they are deductible to him and tax-free to the employee. The employee can continue the permanent insurance after retirement at a premium based on his age at the time the plan was put in force, rather than at the age of

retirement. This gives him coverage at a much lower rate than if he had to convert group term to a permanent contract at age 65.

The employer has an advantage with a Section 79 plan because the costs are level and predictable. Premiums cannot be raised even though group mortality or expenses or greater than expected.

Section 79 plans thus provide the benefits of permanent cash-value life insurance at lower rates than would be possible in individually purchased policies. They are a form of group life insurance designed especially for small and medium sized businesses and offer great flexibility in design. In close corporations, shareholder employees as well as other employees are eligible. An employee will be taxed on any amount of group term coverage that exceeds $50,000, and there are other tax requirements that need to be worked out to fit the needs of each case. Specific information is available in insurance agency or home offices on Section 79 policies.

**The RLR Plan**

Another kind of group insurance plan developed in recent years is designed to provide life insurance for retired employees without the disadvantage of the conventional group term coverage which usually either stops or is reduced when the covered employee retires. It is known as Retired Lives Reserve, or RLR, and is especially suitable for close corporations. If requirements can be met, it offers an excellent fringe benefit plan for corporate owners and employees.

The program is a two-part plan including pre-retirement life insurance under a conventional group term plan and post-retirement group insurance provided by contributions to a reserve fund. The employer makes an annual or more frequent contribution to a reserve fund to provide the premiums for post-retirement group term life insurance at the employees' retirement ages. When employee terminations occur before retirement, the funds set aside for that employee may go to reduce future contributions by the employer.

Guaranteed interest rates are provided by the fund as a general rule. The term insurance may be renewable annually at guaranteed premium rates and may be noncancelable. A terminating employee may continue the coverage without having to convert to a cash value policy. RLR coverage may be superimposed on a conventional group term life insurance plan covering a group of employees.

Part-time employees who work only 20 hours or less per week, or only five months or less in any calendar year, may be excluded, as may employees who have reached the age of 65 or those who have not worked for the length of time set by the waiting period of the policy, not to exceed six months.

**Advantages for Employers**

There are tax and other advantages for employers who put RLR plans into effect. Their contributions to both current and post-retirement protection are tax deductible. Earnings of the RLR fund accumulate tax-free. In addition, the employer knows in advance the cost of the program. It cannot be cancelled by the insurance company. It offers flexible arrangements in selecting employees to be covered.

If an employee leaves the firm before retirement, he has no vested interest in the plan. Only those who stay until retirement receive benefits. The employer, however, has the option of providing for early retirement and disability benefits. Awkward decisions about providing post-retirement insurance for key employees are avoided. At retirement time there are no extra conversion costs. The plan encourages productivity by boosting employee morale.

**Advantages for Employees**

Benefits for employees under an RLR plan are considerable. Up to $50,000 in coverage can be paid for by the employer without being taxable to the employee, and additional coverage is taxable only at moderate rates set by government term tables. Contributions to the fund for post-retirement coverage are not taxable to employees regardless of amount. Death proceeds are entirely tax-free. Estate taxes can be avoided by assignment of the policy and the fund.

Employees receive non-cancelable life insurance coverage, both pre-retirement and post-retirement. They have no expense of conversion at retirement as in traditional group term life insurance. Corporate owners and key employees frequently find that RLR plans are a great help in solving retirement problems. Not all companies have Retired Lives Reserve plans available, and some tax questions in the area may remain.

**Group Health Insurance**

Group health insurance is somewhat more complicated than group life insurance because it involves not only the employer and the insurance carrier, but a third element, the care provider. Confounding matters still further is the adoption of the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA)

While there is no law requiring small business owners to provide health insurance, the Affordable Care Act makes substantial changes that small business owners should be aware of when deciding whether to purchase insurance for their employees. If a small business owner chooses to offer coverage, there are regulations which must be followed, some of which are reviewed in this section.

Blue Cross and Blue Shield pioneered group health insurance, working from the service benefit approach which meant that doctors and hospitals were paid in full for their services. As private insurers entered the field, they paid claims but did not have too much to do with controlling costs.

Medical costs continue an upward trajectory, and claims for more than $100,000 are not uncommon- some can approach the million-dollar mark. Consequently insurance carriers are putting much greater emphasis on monitoring services to see if they are necessary and priced within reason. Blue Cross and Blue Shield have modified their service benefit approach to pay benefits on a "usual, customary, and reasonable" basis.

Some employers have tried to save money by taking on some of the responsibilities of the carrier, or have adopted non-insured programs. Another approach is for the carrier and the provider to consolidate functions, as in a health maintenance organization.

Under a group basic medical plan underwritten by an insurance company, a covered employee goes to any doctor he chooses and there is no limitation on the choice of hospital except for the doctor's preference. The insurance company has no connection with the health care providers. It pays the billed charges to the doctor and hospital just as the patient would if he were paying cash, up to the limits of the insurance contract.

The employee goes in for medical treatment and fills out claim forms, often assigning benefits to the doctor or hospital. These care providers send in the forms and collect directly from the insurance company. The employee, especially in the case of small charges and those for prescriptions, may pay directly and be reimbursed by the insurer.

There are four general divisions of group health insurance basic medical, major medical, comprehensive medical, and accidental death and dismemberment, often combined with life insurance.

**Basic Medical Coverage**

The usual group medical policy is written to cover most of the expenses incurred while the insured is a patient in a hospital. Actual charges for hospital room and board up to a maximum set by the policy are usually included.

Under some plans a flat dollar amount per day of hospital care is set. In some, the maximum amount for room and board is determined by the daily charge for a semi-private room. The number of days for which room and board benefits are to be paid will be specified in the policy. The number may be 31, 90, or higher.

For additional hospital expenses such as laboratory fees, X-ray and drug costs, physical or radiological therapy, there usually is a maximum set either as a multiple of the room benefit or at a specific dollar figure. Payment to physicians other than surgeons is under a separate limit. Group policies also may pay within specified limits for treatment of drug addiction, alcoholism, nervous and mental disorders.

For surgical procedures, there may be a schedule with maximum benefits for each, or benefits may be paid in full according to prevailing fees in a geographical area, called "UCR," meaning usual, customary, and reasonable.

Care for dependents of an employee may be included in a group basic medical plan or may be available if the employee wishes to pay an additional premium.

Before 1979 and the passage of U.S. Public Law 95-555 making discrimination against women on the basis of their sex illegal, there was limited maternity coverage in group health policies. Usually a flat dollar total amount was set or there were separate maximums for the hospital and the obstetrician. The law now requires health-care benefits provided by employers to be the same for pregnancy cases as for any illness. In most group health policies, therefore, pregnancy is treated routinely like any illness or disability.

State laws require conversion privileges to be included in group health plans so an employee who is terminated or resigns can convert his group coverage into an individual policy within a certain period, such as 31 days, without submitting evidence of insurability. Covered dependents also are eligible for conversion privileges.

**Major Medical Coverage**

Group major medical plans may be made available as separate coverage or may be added to a basic medical group plan. They have become popular for providing protection against catastrophic medical expenses, which can bankrupt a family in one episode of illness.

If major medical is a separate coverage, the insured usually pays an initial deductible amount before benefits start. When it is added to a basic group plan, there usually is a provision for an insured to pay a certain deductible, such as $100, after basic benefits are exhausted. The major medical benefits then become available.

Various policies may set the maximum total lifetime benefits of major medical coverage at a specific limit such as $250,000 or $1,000,000, or may be without a set limit. The plans include a co-insurance provision requiring the insured to share certain medical expenses after meeting the deductible. A frequent arrangement is to require the insured to pay 20 per cent and the insurance company 80 per cent of the covered expenses.

**Comprehensive Major Medical Coverage**

As health care costs have continued to increase, the popularity of comprehensive major medical plans has grown. Such a plan under group insurance combines basic and major medical coverage in a single contract.

Most such policies now include outpatient diagnostic X- rays and emergency care physical therapy, prosthetic and orthopedic appliances, and liberal inpatient hospital benefits. The tendency has been to make coverage broader and to pay benefits on the basis of what is considered reasonable and customary in a given area.

As in other forms of group health insurance, deductible and co-insurance provisions are included. There may also be a stop-loss provision of some kind to adjust fluctuations in claims experience. For instance, a group policy premium might include a specific charge to cover a provision that losses exceeding a certain figure will not be charged against the claim experience of the policy.

**Comprehensive Corporate Health Plans**

A form of group insurance coverage proving very popular with companies employing a group of employees is the comprehensive corporate health plan, which usually includes both medical expense and sick-pay (disability) protection. A small corporation, for instance, with 15 to 20 full-time employees could offer a group insurance plan providing basic medical coverage, short-term disability income, and group life benefits for all full-time workers. The corporation could in addition secure major medical and long-term disability coverage for a select group of employees on either a group or individual basis. A class of employees such as executives or supervisors might be named for these benefits.

If the group included stockholders, one or more stockholders might be included in the plan. Uninsured benefits such as payment of an employee's salary during an initial period not covered by group disability income insurance could be included.

The cost of the corporation's contribution to benefits under the plan would be tax-deductible, and the benefits would be tax-free to employees except for sick pay, which would be partially taxed. A proprietorship or partnership could set up such a plan for its employees, but benefits paid to the owners would be taxable in that case. The plan therefore is especially favorable for a corporation. A small corporation may not be able to provide a comprehensive health plan all at once, but can start with a basic medical expense plan an add other elements as needed.

Some benefits may be uninsured, but group insurance gives the advantage of being able to budget costs and avoid the possibility of having to make large payments of cash unexpectedly. A group insurance policy also makes it possible to have documentation for the health plan and to communicate it to the employees, assuring that requirements for tax deductibility will be met.

The insurance agent works with corporation officers in determining what needs are to be covered. When the plan is decided on it must be formally drafted and adopted by corporate resolution, then communicated to employees in order to meet IRS requirements.

**Group Dental Coverage**
Dental insurance plans are growing in popularity, although there is considerable variation, from limited amounts to comprehensive plans. They may be offered as a package with other group health insurance or issued separately. Minimum size groups also vary. Usually there is a deductible and co- insurance provision.

Benefits usually are offered for cleaning, X-ray examinations, fillings, extractions, bridgework, inlays, oral surgery, root canal therapy, orthodontics, and dentures. Usually not included are cosmetic services or those made necessary by occupational injuries, sicknesses, or war injuries.

**Medicare Supplemental Benefits**
Most group health plans include supplemental Medicare coverage for insured persons or dependents 65 or over, or those covered by Medicare at younger ages because of disability. Medicare benefits are paid first, then those from privately insured group benefits.

**Coordination of Group Health Benefits Provision**
Where there is coverage from more than one source, the coordination of benefits provision applies. The liability of each insurance carrier is generally applied in a specified order. The primary insurer pays its full benefits and the secondary insurer follows with payment on the balance up to the limits of its policy. Unnecessary duplication of benefit payments and the possibility of over-insurance are prevented by the coordination of benefits provision. The total of all insurance benefits paid from group plans is limited to total allowable expenses.

**Group Accidental Death and Dismemberment Insurance**
Usually group accidental death and dismemberment insurance is combined with group life insurance plans, and the face amount or principal sum matches the amount of group term life coverage issued to group members.

Group AD&D, as it is known, generally does not include conversion or assignment privilege and usually terminates at retirement, though it sometimes may be continued for employees who are temporarily not at work.

The full principal amount of the policy normally is payable in a lump sum for accidental loss of life or of any two body members, such as arms, legs, hands, or feet, or the sight of both eyes. One half of the principal sum is payable for the loss of one arm, leg, hand, or foot, or the sight of one eye, through accident. Payment of benefits for suicidal deaths is excluded, as are losses from disease, ptomaine, or any infection other than one resulting from an accidental cut or wound. Also excluded are injuries or death resulting from flying in an aircraft as a pilot or crew member, or from an act of war.

Voluntary group AD&D coverage is available in separate non-cooperation policies at amounts that can be elected by employees. Some plans cover dependents. Travel accident coverage also is available for employees while traveling on employer business.

## Commonly Used Health Insurance Terms

**Accidental Death and Dismemberment Insurance**
This form of health insurance pays death benefits if the insured dies as the result of an accident, and also pays the principal sum if the insured suffers the loss of both arms, both legs, or both eyes, or half the principal sum for the loss of one arm, one leg, or one eye.

**Actively at Work**
A requirement for beginning coverage for an individual employee under the assumption that if an employee is able to be on the job, he qualifies for all of the insurance coverage.

**Ancillary Benefits**
Additional or secondary benefits added to basic medical care, including X-ray and laboratory services and other services or supplies.

**Assignment**
In health insurance, the signing over of benefit payments to a hospital or other provider of medical care. In general, assignment is a provision regarding transfer of an insured's rights. In life insurance it refers to conveying the benefits to a third party. The insurance company does not guarantee the validity of an assignment.

**Benefit Period**
The maximum length of time for which benefits will be paid under health insurance in the case of any one accident, illness, hospital stay, or disability.

**Birthing Center**
A state licensed facility designed to provide short-term confinement for the delivery of a baby. Pre-certified admissions to a birthing center are often required.

**Blue Cross**
The original independent membership association for providing protection against hospital care costs. It makes payments directly to hospitals.

**Blue Shield**
An independent membership group, Associated Medical Care Plans, cooperating with Blue Cross to provide protection against medical care costs. Benefit payments are made directly to physicians.

**Coinsurance**
An arrangement under which a company insures only part of a potential loss while the insured is responsible for the other part. In major medical insurance benefits usually are paid on a 25-75 or a 20- 80 basis, the insured being responsible for the smaller percentage.

**Corridor Deductible**
Out-of-pocket deductible required in some major medical plans following the expiration of base plan benefits and before the point where major medical benefits apply.

**Covered Medical Expenses**
Major medical and health insurance policies in general do not cover all expenses resulting from illness or accidents. Each policy enumerates covered expenses and specifies excluded items and benefit limits.

**Deductible**
A deductible is an amount of money that an employee must pay for covered medical expenses. Once a specified number of family members has each satisfied the annual deductible, other family members are covered without an annual deductible.

**Emergency Accident**
A benefit, not subject to a deductible, providing for outpatient coverage for treatment given within 90 days of an accident.

**Extended Care**
Benefits for medical care beyond hospital confinement, which may or may not be included in a group policy. Care in a convalescent facility, which is less expensive than hospital care, is included in many group policies.

**Handicapped Child**
A specific provision is carried in many group contracts now, often under state law requirements, that coverage of child dependents is continued regardless of age if the child became handicapped while covered under the policy.

**HMO (Health Maintenance Organization)**
An organized system of health care delivery stressing preventive health care, early diagnosis, and outpatient treatment with financing through a fixed regular payment.

An HMO provides a broad range of services to a group of persons who are voluntarily enrolled in it.

**Home Health Care**
Services and supplies rendered by a legally licensed home health care agency in the home of a plan member that would normally be rendered and covered in the hospital.

**Hospice Program**
A health care program designed to provide relief from the symptoms or effects of a terminal disease without attempting to cure the disease.

**Hospital Miscellaneous**
Charges made by a hospital in addition to those for room and board, including operating room fee, laboratory services, drugs, dressings, anesthesia, and other charges, though not including on a reimbursable basis items such as TV and telephone billed by the hospital.

**Intensive Care**
Treatment provided patients in the specialized unit of a general hospital devoted to intensive care and coronary care.

**Medicare Supplements**
Policies providing coverage in addition to benefits paid by federally sponsored Medicare for those 65 or over or receiving disability benefits under Social Security.

**Out-of-Pocket-Expenses**
These are expenses not intended to be covered by insurance or reimbursable by insurance at a later date. Deductibles associated with the annual medical insurance portion and stays in the hospital are out-of-pocket expenses. Co-insurance expenses will be an out-of-pocket expense. The out-of-pocket expenses may be deductible by the individual for income tax purposes.

**Outpatient Surgery**
Recent advances in medicine make it possible to perform operations on an out-patient or day surgery basis. The patient goes into the hospital or clinic during business hours for the surgical procedure then goes home to recuperate. Advantages of outpatient surgery include lower costs, freeing of hospital beds for serious illnesses, and faster recovery by the patient due to the familiar surrounds of their home.

**Pre-Existing Condition**
A condition or illness that existed prior to the issuance of the medical insurance policy. The pre-existing condition may not be covered under the policy, or may not be covered for a stated amount of time.

**Rehabilitation**
Provision under which a claimant receiving benefits under a long-term disability (LTD) plan may continue to receive at least partial payments while being retrained and looking for new employment.

**Reimbursement**
Payment by an insurer to compensate the insured for a loss of a sum of money related to a covered expense or incurred by or on behalf of the insured, such as under group medical expense coverage.

**Reinstatement**
A provision in major medical contracts under group insurance allowing portions of the maximum benefit that have been exhausted in prior claims to be reinstated after a specific period in which no benefits are paid.

**Reinsurance**
Sharing a risk too large for one insurer with another company or reinsurer.

**Relative Value Schedule**
A scale of difficulty for rating surgical procedures, by which an operation which may be three times more complicated than another is graded and made allowance for accordingly.

**Semiprivate**
Payment for a semiprivate hospital room usually is provided in medical expense insurance. If a private room is used without a doctor's order, the difference in charge from that for a semiprivate room is not reimbursable.

**Underwriting Principles and Controls**

Successful underwriting requires a system of risk selection to obtain a group in which loss results will be reasonably predictable by means of the law of averages. To accomplish this goal there must be a balance between obtaining volume and obtaining homogeneous risks.

If an insurance company issuing individual life policies, for instance, adopted such strict standards that it would only accept individuals who were practically perfect physically, ideal from a moral standpoint, and in risk-free occupations, there would be only a very small group to choose from.

Such a group would be very homogeneous, with all the risk units--in this case the individual lives--subject to about the same chance of loss. But the mass or volume of risk units would be very small, and thus the predictability of loss might be adversely affected.

Another element entering in to make selection of such a group impractical would be that selection procedures to obtain this near-perfect set of individuals could be so difficult and complicated that the expense involved would more than offset the savings from the mortality rate of the group. In underwriting, selection expense is a factor to be considered. There has to be a balance between the strictness of selection standards and the necessity of having a large volume of risk units to be insured.

Group life insurance selection standards are set up to achieve this balance. Usually group insurance companies adopt selection standards broad enough to permit acceptance of the large majority of insurable risks at standard premium rates.

Certain groups employed in hazardous occupations will have mortality rates consistently higher than standard risks. They have to be classified as substandard risks and a policy covering them would have a higher premium rate. A risk may even be rejected entirely because the mortality rate is too great or too unpredictable for insurance to be practicable.

The chance of loss is never exactly the same for all risks or groups, even within the classification of insurable risks into the standard class and several substandard classes. In each class there are good risks and poor risks relative to the rest of the class.

It is the goal of the insurance underwriter to establish rules which will result in securing an average proportion of good risks. If the underwriter can accomplish this goal, the company's average mortality cost will be lower and the company may be able to offer insurance at a lower net cost. The practice of experience rating helps in achieving this goal.

The rules adopted by various companies to secure the desired result will vary, based as they are on the individual company's experience, research, judgment, and, at the end, intuition. But the aims they are trying to achieve are basically the same.

**Balance Needed**
For successful operation in the insurance field, the rules established by any company need to achieve the proper balance between mass and homogeneity of risks to achieve predictability of future results. The rules should establish standards permitting acceptance of the large majority of risks at standard premium rates. They need to secure the largest possible proportion of the average risks within each classification.

In order to achieve this proportion, a company may establish a policy of accepting borderline cases which would not be a gain from the underwriting standpoint but would provide volume to spread out overhead expense.

**Group Selection Theory**
In selling private life insurance, a company is not dealing with a group and therefore has to take precautions to secure individual risks making up a volume of coverage with an average rate of mortality. Individual selection methods such as medical exams and other sources of information must be used.

In group insurance, however, the underwriter is not concerned with the health, habits, or morals of any particular individual in the group. The group itself is the unit of selection. The aim in group insurance is to obtain a group of individual lives, or more important, a group of such groups, which will yield predictable results.

The necessity in such underwriting is to achieve the proper degree of mass and homogeneity of risk units. If this goal is achieved the adoption of the group as the unit of selection is theoretically sound.

To assure that the group is satisfactorily homogeneous, the underwriter must determine that certain essential features are inherent in the nature of the group, or if they are not, that they may be applied in a positive way to avoid adverse selection by an entire group or by individuals within a group.

**Nature of Group**
The basis of the group is one of the first elements an underwriter considers. What is the inherent nature of the group? If it is based on some natural, pre-existing relationship, representing a group of individuals bound together by some other interest than that of obtaining low cost insurance, a group selection plan probably will be feasible.

If the group is organized mainly to obtain group insurance, the underwriter has to consider the possibility of selection against the insurer. Individuals with poor prospects of being insurable otherwise would tend to seek and maintain membership in the group, while healthy individuals might be indifferent to joining or continuing their membership.

Thus a workable plan almost always requires insurance to be only a secondary or unessential element in the formation and existence of the group. A trustee group established by several employers in order to obtain group insurance for their employees might appear to be an exception to this principle, but actually such an arrangement produces a group of groups, none of which was formed to secure insurance, and thus the possibility of adverse selection against the insurer by individuals is not large.

**Flow Through the Group**
Another element generally considered essential to successful group underwriting is a steady flow of individuals through the group. A stream of new individuals entering the group represents the addition of young, healthy prospects, and a flow out of the group of older and less healthy individuals keeps the insurability of the group more or less stable.

**Automatic Benefits**
In order to prevent individual selection by either the employer or employee, the amount of benefits under a group policy must be determined in some automatic way. If employees had the option to take varying amounts of insurance at their own choice, the poor risks would insure heavily and the healthy ones would

not. If the employer had complete control of determining the amount of insurance on individuals, it would be easy for him to select against the insurer for the benefit of certain employees.

Such selection by either employer or employee would greatly increase costs under the policy and probably would result in failure of the plan. In actual fact, the employer does have some say in selecting the schedule of insurance and no doubt sometimes does have particular individuals and their needs in mind in such selection.

It is also necessary to have an automatic determination of the time when benefits become effective under the policy. Unless an employee had to apply for his benefits within a reasonable period or else submit evidence of insurability, there would be an opportunity for him to select against the insurer.

**High Proportion of Participation**

All or substantially all eligible persons in a given group covered by insurance must participate in the plan for sound underwriting. Only by covering a large proportion of a given group does an insurer achieve a positive safeguard against an undue proportion of substandard risks.

In a noncontributory plan all employees, or at least all in a given class, must be insured. When employees contribute to the plan, the requirement is that at least 75 per cent of eligible employees must be enrolled when the plan is issued and thereafter. Allowing less than 100 per cent coverage in contributory groups does introduce some chance of adverse selection, but the over-all spread of risk is increased because many employers will buy insurance on the contributory plan who would not accept a plan under which they had to pay the full cost.

**Cost Sharing**

Most insurance companies will not write group insurance unless the employer or other third party shares in the cost, because a member-pay-all plan carries the seeds of its own destruction.

Some plan of averaging individual premiums is necessary, and under member-pay-all coverage, the younger members help pay for the older members. As they realize this fact, the younger members tend to leave the group and buy insurance cheaper elsewhere. The situation is thus aggravated as average premiums are raised still more. Eventually the aged and impaired members predominate in the group and the necessarily large premium charges cause the plan to fail.

In a conventional group plan, participation by the employer in sharing the group cost permits employees to buy insurance at relatively low rates, making it attractive for them and making it possible to get a sufficient number of eligible employees to participate so as to avoid adverse selection.

**Efficient Administration**

To be successful, a group insurance plan must require a minimum amount of effort on the part of the employer. If members are to contribute to the cost of the plan, there must be some simple, automatic method for them to pay their share, such as a payroll deduction plan. If each person had to choose on payday between paying his insurance premium and spending the money otherwise, it is likely that a large number of employees would lose interest in the plan very quickly.

There are many other details connected with the operation of a plan which would discourage employee participation if they had to be handled directly between the insurer and the employee. There are enrollment and payroll deduction forms to be filled out in addition to change of beneficiary, change of name, and increases in amounts of insurance, all requiring different forms.
The employer normally handles these details with only a minimum of effort required from the employee. Many people would drop out of a group rather than do paper work to remain in it.

**Other Controls**

There are a number of other miscellaneous controls that may be included in underwriting rules as further safeguards against adverse selection. These include the probationary period which must be served by an employee before he becomes eligible for group insurance, the definition of eligible employees, the "actively-at-work" rule, the eligibility period rule, the requirement of evidence of insurability for late applicants and for excess amounts, and the form of the insurance amount schedule.

**Selection of Groups**
In underwriting group insurance a company may use somewhat less stringent rules than for ordinary insurance. Underwriting principles and controls still prevail, and each group risk applying for group insurance must be evaluated for the minimum selection standards established by the insurer. It is a fact, however, that in writing individual insurance, once a company approves and issues a contract it assumes the risk without any right to cancel, change the contract, or increase the premium rate.

In group insurance, on the other hand, the premium rate can be changed, usually on the policy anniversary, and with the agreement of the policy holder the schedule of benefits or other provisions can be changed.

Also group insurance is subject to experience rating by which subsequent dividends or premiums can be adjusted. The risk assumed when the policy is initiated can be re-evaluated through renewal underwriting. For good policy holder relations, however, it is desirable to set the initial premium rate with adequate margins so as to avoid rate increases if possible.

There still must be detailed selection procedures to measure the factors affecting the insurability of individual group risks. Each group must be closely examined both before the contract is issued and before its renewal in order to evaluate the risk and the administrative feasibility involved.

**How Information Is Obtained**
A home office in judging the insurability of a particular risk uses three basic sources. The most important consists of reports of group representatives and underwriters. These may be in the form of correspondence about the risk or may be a formal report included on the reverse side of the preliminary application form.

The report would include information about the nature of the employer's business, the branches, subsidiaries, and affiliates of the business with their locations and whether they are to be covered, the effective date of the coverage and amount of advance premium payment, the total number of employees eligible, any personal knowledge of the case the representative might have, and usually an expression of opinion as to whether the case is a good risk.

Next in importance to the decision is the application form signed by the employer. This contains a limited amount of information compared to an application for an individual life insurance policy. It indicates which classes of employees are to be covered, how insurance is to be allocated, whether the plan is to be contributory or noncontributory, and how premiums are to be paid. Usually the application includes a question as to whether other group insurance has previously been carried and if so the name of the other carrier and the reason for termination.

Sometimes in small cases the home office will want more information or will want to verify statements on the application. A private reporting firm may be asked to provide an inspection report in such a case. In some cases where risks are known to be high there may be a report on the physical hazards involved.

**New Business Selection**
An underwriter in examining new business applications wants to know first whether the agent and the group representative have followed the basic underwriting rules of the company conforming both to law and to company policy. If these rules have been followed, the underwriter then moves to determine whether the risk is a good or poor one from the standpoint of future costs and administration expense.

The underwriter must know if a group of employees is subject to exceptional hazards from occupational disease or industrial accident. In such a case the hazards might be reduced or eliminated, the risk might be classified as substandard and charged a higher premium, or the risk might be rejected altogether.

In the early days of group insurance when industrial working conditions and general living conditions were much worse than they are now, such factors were of great importance. They are less important practical considerations now.

**Allocation of Benefits**
The way a plan is set up to allocate benefits has a bearing on underwriting. If there is a large spread

between the amounts of insurance available to adjacent classes, the plan is likely to suffer from declining participation. If an employee in getting a small salary increase or promotion to another rank becomes eligible for much larger insurance coverage, he may drop out of the plan rather than pay the increased premium contribution. Schedules which pay disproportionate amounts of insurance to top executives also must be checked closely under current tax rules.

Past experience on a risk is an important factor for an underwriter. If the group was previously insured with another carrier and the employer terminated the policy to avoid a rate increase caused by poor experience, the underwriter needs to know. Other factors which need to be examined are high turnover of employees and seasonal employment. High turnover probably means excessive administration expense and often poor administration by the employer. The number of persons eligible to convert their group certificates to individual policies is greater with a resulting increase in adverse selection.

A probationary period longer than usual can in many cases solve the high turnover problem. The seasonal employment problem may be solved by limiting coverage to permanent employees and to groups operating for a minimum period, such as eight months a year.

Having employees in scattered locations also poses a problem. Separate branches, plants, or stores, particularly those with only a few employees in each location, may cause considerable problems in administering the plan. A plan on a contributory basis will tend to have decreasing participation in the smaller outlying units. Risks with widely scattered locations frequently are acceptable only on a noncontributory basis and then only if there is good administration through a centralized responsible authority.

Even after a check-off of these and other factors considered by the group home office underwriter, there remains a subjective factor in underwriting--intuition or a "sixth sense" which an experienced underwriter is generally conceded to have.

**Rules for Small Groups**

Companies writing wholesale or franchise insurance have in the past adopted stringent underwriting rules for groups of 25 or fewer. These small risks, sometimes called "baby group" cases, in the beginning were accepted only at premium rates higher than standard in the hope of covering the extra expense and extra risks involved. Competition, however, forced the rates down, and as a result additional underwriting safeguards for this class of business were developed. The Affordable Care Act has changed the economics for small group insurance, now including 1-100 employees.

Evidence of insurability may be required through a short health form, either from all employees or from those in the highest insurance class or over a certain age, such as 50. Employees who do not have satisfactory health questionnaires may be excluded or limited to the lowest amount of insurance in the schedule.

The two-and-one-half-times rule may be applied in the schedule of insurance offered, with the top amount not more than two and a half times the smallest amount offered. The percentage of participation required in the case of contributory plans may be higher than the standard 75 per cent. A preliminary application with a census of employees and possibly an inspection report and other data may be required.

Administration cost of small group cases was a factor in more restrictive underwriting, but the development of electronic data-processing equipment has made it possible to reduce such costs.

**Renewal Underwriting**

An underwriting department in a group insurance company has two basic functions to underwrite new business and to underwrite contract renewals. Most group insurance is written on a term basis with a one-year guarantee of premium rates, so the renewal underwriting must be done annually.

In the consideration of renewals, the underwriter is concerned with risk experience and participation level on contributory plans. The experience with risks is examined both for the current year and for the accumulated years the risk has been carried, to determine absolute loss results and the appearance of any trends. The underwriter may go into the claim history if poor experience is shown in order to learn if preventive

measures can be taken.

It may be that improved participation, a revised insurance schedule, a longer probationary period or other means of exclusion of a class of employees can help the experience. Sometimes a group company will audit the employer's administration of the case to be sure there has been a full reporting of the volume of insurance in force and the full premium has been paid.

In case of poor experience consistently over several years, the company usually will raise the premium rates at the time of renewal. The company may not specifically have the privilege of refusing to renew the group contract, but since premium rates usually are guaranteed only for one year, the company can raise the rates so much as to result in cancellation.

The extent of participation in the case of contributory plans is considered by the underwriter along with the risk experience. Frequently there is a direct connection between loss experience and participation. Where participation is low, there tends to be a poor loss experience.

If participation is below 75 per cent of all eligible employees on the renewal date, the company may refuse to renew the policy. This right is always reserved in the master contract. The company usually will try other measures before terminating the contract, however, such as agreeing to renew on condition that participation is raised to 75 per cent, conducting a campaign to increase participation, or agreeing to renew the risk without limitation.

**Use of Reinsurance**

Insurance companies generally set limits on the amount for which they will insure any risk. Life insurance companies have a limit beyond which they will not assume the risk on a single life. Fire insurance companies set limits of risk on individual buildings and on fire areas and casualty insurance companies set limits to their liability exposure on any one risk.

Life underwriters set limits mainly to avoid accidental fluctuations in the mortality rate among the heavily insured. Some insurance companies, however, may assume a large risk on an individual life because they can pass on the excess liability to another company or to a combination of companies by means of reinsurance.

Reinsurance in the past has not been in general use for group insurance because the size of individual certificates usually is not large and because the risk is spread over so many individuals. It was considered that there was such a dispersion of the insured individuals, both on and off the job, that the chance of catastrophic loss was slight.

The Texas City explosions and fires in 1947 produced some change in this thinking. One company that had written group insurance in the area paid more than a million dollars in group insurance death claims from one insured risk. This incident, along with the possibilities opened up by new developments in nuclear and chemical technologies, led insurance companies to increased consideration of reinsuring excess hazards for group operations.

There are also instances in which reinsurance is used for sharing business rather than sharing hazards. A large company might want to favor more than one insurer by dividing its group program between several carriers. Sometimes in the consolidation of several plans which have been carried with two or more insurers the policy holder may wish to keep all the companies in the plan and thus places the combined plan with one insurer and gives instructions to have the others participate.

If a buyer has negotiated with several insurers and has business, financial, or personal relationships with more than one of them, he may wish to share the business among them. He may also want to get independent advice from competing sources and thus may have two or more group companies furnishing his coverage.

Business can be split among companies in several ways. It may be divided by means of reinsurance, coinsurance, distribution by geographical location, or distribution by type of coverage.

**Reinsurance Methods**
The most used method of sharing a large risk and generally the most satisfactory is reinsurance. Under this arrangement one company is the insurer and issues a master contract to the employer to cover the entire risk. This company is responsible for the entire administration of the program, including all transactions with the employer and the certificate holders.

The employer has told the company at the time of establishing the contract that he wants certain percentages of the risk reinsured with a second and third company. These reinsuring companies agree to let the insurer follow its own practices. The reinsurance normally represents a percentage of the insurance on each certificate holder, rather than all the insurance on a percentage of the covered group.

The primary insurer remits an amount to the reinsuring companies representing their share of the premiums less their share of the claim payments, less a charge for administrative expense and any taxes or commissions paid by the original insurer on the reinsuring companies' share of the business.

The final determination of premium rates and experience rating adjustments usually is left to each reinsuring company on its own share of the business, although usually the results are quite uniform. This arrangement, called a "New York style" reinsurance treaty, is necessary when the reinsuring company is a mutual company and must follow its own dividend formula.

If the reinsurer is a stock company, the arrangement more likely would be of the "Hartford style" under which the direct writing company sets the premium and experience ratings and passes on a share of the net result to each reinsuring company.

An advantage of the reinsurance method of sharing business is that there is little additional expense under this arrangement over a plan involving only one company. The extra expenses are only those in connection with the original reinsurance agreements between the companies and the monthly wholesale accounting statements of premiums and claims. Commissions on the risk are usually started from the top of the graded commission scale only once instead of once for each company involved.

The employee deals with only one insurance company in administrative matters such as claims and conversions. Group reinsurance does carry some additional cost to the policy holder, but for the large risks in which it is usually concerned, this cost is a relatively insignificant part of the premium.

**Terrorism and Reinsurance**
The terrorist attacks of September 11, 2001, inflicted enormous personal and property losses on the United States. An event like 9/11 can be itemized, but it is hard to settle on one particular number; there is little consensus on what counts as a direct cost of the attack. Certainly the insurance cost of around $40 billion counts, as does the cost of rebuilding the World Trade Center (roughly $700 million). With business losses, however, the numbers get fuzzy. Coverage is difficult to obtain, especially for buildings or sites that are landmarks; where coverage is available, prices are high and restrictions are numerous.

Congress enacted the Terrorism Risk Insurance Act (TRIA) in November 2002 to provide a government reinsurance backstop in case of large-scale terrorist attacks, requiring that business insurers offer terrorism coverage for the types of insurance included in the act. The Terrorism Risk Insurance Program Reauthorization Act of 2015 extended the program through 2020. Under TRIA, the federal government would help insurers cover losses in the event of a terrorist attack under certain conditions, and would also impose assessments on the insurance industry to recover all or a portion of the federal payments.

Policymakers have developed two types of federal proposals to increase the supply of property and casualty insurance. Under one set of options, which was created following Hurricane Andrew in August 1992 and the Northridge earthquake in January 1994, the federal government would auction reinsurance contracts to primary insurance companies and state-sponsored insurers. Reinsurance is an established practice among private insurers. By buying reinsurance, primary insurers spread the risk of loss more widely and strengthen their ability to insure against catastrophes. The intent of those proposals is to offer federal reinsurance when coverage is in short supply, at market prices that are expected to cover the government's costs. By contrast, under proposals developed since September 11, the government would pay for most losses from a terrorist attack directly, without reimbursement or with only partial

reimbursement. Even though one type of proposal was created in response to natural disasters and the other from an act of terrorism, both types could be considered viable alternatives, whatever the source of catastrophic loss.

A key consideration in Congressional deliberations about disaster reinsurance was how the property and casualty industry would respond without federal intervention. That is, would the private supply of insurance rebound quickly? A fast recovery would counter a potential slowdown in construction, an industry in which insurance is often required for financing. Alternatively, is the risk of terrorism uninsurable, such that supply could not recover without the government's assistance? Furthermore, given that the Congress may need to act without fully understanding the industry's ability to respond, are there policies that could avoid undermining private activity while providing a backstop to private efforts if they proved inadequate? How much would such policies cost taxpayers and the government?

**Coinsurance Sharing**

In the coinsurance method of sharing a group risk, a separate policy is issued by each company to cover part of the insurance on each individual. Each company handles its share of the risk more or less autonomously.

This plan generally results in greater over-all retention of premiums for expenses and is unsatisfactory from the employee's point of view because in the event of conversion he would have to take out a separate small policy with each of the companies involved. The coinsurance arrangement is declining in use and such policies already in place are often administered in a similar manner to reinsurance.

**Geographical Location**

A group risk may be shared among several companies through distribution by geographical location. One company might provide all the group insurance at one location, another company at a second location, and a third at still another. This method of sharing may be useful in cases where separate plants are located in different communities with different employment markets, wage levels, and health care costs. There are administrative difficulties involved, however, which may raise expenses.

Unless all the companies adopt uniform procedures, the transfer of employees from one location to another may cause handling difficulties, overlapping coverage, or gaps in coverage for transferring employees. Also the employee may be entitled to convert his group insurance every time he transfers.

**Distribution by Type**

An employer may distribute his group insurance business among various companies by type of coverage. He might place his group life coverage with one company, group health with another, and group annuities with a third.

This arrangement may lead to additional expense in enrolling employees if the plans are contributory, and there will not be uniform administrative procedures for the various group coverages. Also since the premium base is not as broad, the experience rating may not give as great an opportunity for premium savings. Otherwise this type of coverage distribution has been found to operate about as satisfactorily as reinsurance.

**Group Selection**

In group insurance, the make-up of the group is the most important element. Small groups in order to maintain solvency require some means of pooling risks. The underwriter must guard against anti- selection.

If an employer puts his terminally ill brother-in-law on the payroll even though he is not able to work, the employer is "selecting" against the insurance carrier. This is a case of anti-selection, or adverse selection. Insurers must have underwriting rules and limitations for their own protection against this and similar practices. They also must comply with various federal and state regulations, and still offer policies which are competitive in premiums and benefits.

Underwriting rules necessarily are more restrictive for small groups than for large ones. The group representative in an insurance company is a specialist who will be primarily responsible for selling the

company's group products and will be able to explain the small group plans so that agents can handle the sales situations themselves.

There are various types of group insurance including the following:

**Jointly Managed Funds**
A collective bargaining agreement under the Taft-Hartley Act can set up a jointly managed health and welfare fund under which the employer pays a contribution to the fund for each employee covered. The amount fixed by the agreement may be a certain sum per week or per month, or a set amount per hour worked.

A board of trustees made up of an equal number of representatives from management and from labor has control of the fund, determining how the contributions are to be used in providing coverage.

An administrator handles the actual day-to-day operations of the fund with regard to eligibility of members, collection of contributions, and paying out operating expenses and claims. A fund may have its own salaried administrator, or may use a contract administrator who works for several funds.

Taft-Hartley funds are especially used for groups with high mobility, such as construction workers, who would seldom be on one job long enough to establish eligibility otherwise. Also a small number of union members working for one employer may join with members of the union employed by other firms.

**Employer-Employee Plans**
Group programs established through arrangements involving employers and employees are the most familiar type to those working in small businesses. There are three basic kinds;
1. Association group insurance
2. Multiple employee trusts
3. Direct coverage, either through a self insurance plan set up by the employer or, most frequently, through an insurance contract between the employer and an insurer covering a group of employees, with no outside organization involved.

**Association Group Insurance**
Lillian Lightfoot has a dance exercise studio with eight employees. She belongs to a national dance exercise association. Although she gets a number of benefits from her membership such as keeping up with the latest trends in aerobics through the association magazine and buying supplies at a discount, one of the most important reasons for belonging to the association is that it offers a group insurance program. She and her employees are covered for health care, group life insurance, and disability income at a lower rate than could be obtained elsewhere for such a small group.

Besides trade and professional associations, other groups such as franchise holders or dealers can provide such insurance coverage. The relationship between the employer and the sponsor is what makes possible the coverage through association group insurance. Premiums must be established at an adequate level to maintain suitable reserves and pay claims properly. Usually the employer who participates has a choice of several levels of benefits under a master plan with variations available to give the flexibility needed by small employers.

Effective marketing and administration are essential for the success of such a plan. Some large trade associations have their own staff of specialists to handle the administration of the program and the solicitation of new memberships. A second method is for the insurance company to collect premiums, maintain employee eligibility records, and handle other administrative matters. Insurance company representatives may also handle solicitation of new members, but this is more often done by the trade association itself.

The third and most common approach is for the broker to handle the entire administrative program and also solicit new memberships with the endorsement of the association or parent company. Association group insurance is a highly specialized field, but it can be a large-scale and successful program if properly administered.

**Multiple Employer Trusts**

For employers who are not members of an association, a multiple employer trust (MET) can provide association group coverage. What the MET sponsor does is to create an association especially for the purpose of providing group plan coverage to a number of small employers joining together to secure advantages otherwise available only to large firms.

These plans are created under Section 419A of the Internal Revenue Code, which exempts multiple employer funded welfare benefit plans from the strict funding limitations contained in Sections 419 and 419A. Multiple Employer Trusts can be used to fund either medical, severance or life benefits without regard to funding guidelines, types of policies or compensation limits. The use to fund severance pay benefits may not be wise, as this type benefit can resemble deferred compensation plans, and deferred compensation of any type is not allowed in a welfare benefit plan (Revenue Ruling 95-34). Outside of this proscription, the plans can be selective as to who is covered and how they are covered.

A legal trust is established under the MET plan to hold the master contract. It is the entity through which all financial transactions related to the plan occur. The sponsor of the plan, either a broker-administrator or an insurance company, sets up the underwriting criteria and administers the plan. There is no association or corporation involved as there is with an association group plan. Thus most MET coverage is placed through insurance agents and brokers just as direct insurance is.

Multiple employer trusts or association group plans sometimes are the only way in which small firms can purchase group insurance coverage. In a number of states, group life and group health coverage in the past could only be provided to groups of ten or more employees. This requirement could be waived in most states, however, if the master contract applies to a group of more than ten insured through an association group or multiple employer trust. The Health Insurance Portability and Accountability Act of 1996, along with the phase-in of health insurance premium deductibility for the self-employed, have changed the entire thrust of group insurance in the last few years.

As an example of MET coverage, suppose Lillian Lightfoot's dance exercise association had not offered an association plan. With only eight full-time employees, she probably would be a good prospect for MET coverage. She or her benefits advisor can consider METs being offered by several broker-administrators and by several insurance companies specializing in the field.

Some of the insurance companies will offer more than one MET. One has a dozen METs, each one covering a specific related industry. Other METs may be for all employers regardless of industry, provided certain underwriting rules are observed.

MET sponsors choose to offer this type of insurance because they can provide a better package of benefits for small employers at lower cost and thus meet the competition. Usually the MET plan is more flexible than the association group plan.

Lillian Lightfoot might select an MET with ten different benefit schedules which thus can provide the level of benefits she wants to offer her employees, almost as if she were signing up for a non-MET plan with an insurer directly. When she has made her selection, the case is submitted just as a directly written group case would be, except that her check is made out to the MET trust, not to the insurer.

**Group Plan Problems**

MET and association group plan premiums usually are based on all employer groups in the plan. If there are excessive claims from some of these groups, the rates for all the employer groups will be driven up. This may result in loss of the groups with good records which will go looking for lower rates elsewhere, leaving the MET with a higher proportion of heavy-loss groups.

There is also a problem with setting rates at a level to be competitive and still keeping them high enough to provide sound reserves and pay claims. These METS are usually self-insured and may not have been thoroughly examined by regulatory agencies for financial stability or capital.

If a MET runs out of money, employers and employees are left without coverage. METs turn to self-insurance or spread their insurance among several carriers when they grow in size and an insurance company becomes reluctant to act as the sole insurer, having very little control over underwriting and

administration of the MET. The insurance carrier also may not want the MET to represent too large a proportion of its total business.

Nevertheless, depending on the soundness of the sponsor, there can be and are excellent METs, some sponsored by insurance companies and some by broker-administrators, which have operated effectively and provided coverage at reasonable cost for a number of years.

**VEBA Plans**
Another type of multiple employer welfare benefit plan available under Section 419 of the Internal Revenue Code is the Voluntary Employees Beneficiary Association (VEBA) plan. This is a tax-exempt trust authorized by §501(c)(9) of the Internal Revenue Code. These plans are set up with the goal of providing certain types of benefits for employees of the sponsoring employer. Practically any type of business can establish a VEBA for the benefit of its employees. This includes owner-employees. According to recent IRS data, there are over 10,000 VEBA plans currently in place in the U.S.

Assets held in a VEBA are secure from the hands of creditors, thus protecting the resources of a business (and its owners) from creditor lawsuits. The trust assets are held by the VEBA, not in the individual's name. The holdings are for the exclusive benefit of the participants and their beneficiaries. As a result, VEBA plans can be used to buy large amounts of life insurance on a tax-deductible basis. The policy, a VEBA plan asset, has a death benefit which is received income and estate tax free by beneficiaries. VEBA assets cannot be returned to the plan sponsor. The sponsor has no ownership rights in the VEBA and each participant can make an irrevocable designation of a beneficiary, usually a trust for the benefit of surviving family members. Plan benefits rely on a formula using annual compensation. An actuarial basis is used to justify contributions and benefits. An independent trustee holds VEBA assets and their reversion to the employer is prohibited. The plan can be modified or terminated by the independent action of the employer at any time. A 1997 tax court case (*Booth v. Commissioner)* set new parameters for these plans. As with all plans, one should check with legal and financial advisers before establishing a plan.

**Direct Insurance**
Most employee benefit programs today are sold through direct insurance company contracts. Instead of an association or MET holding the master contract, it is held by the employer. Most firms with 25 or more employees are directly insured.

**Determining Costs**
In determining the cost of group insurance to the employer, there are three major steps

1. Establishing the initial premium
2. Setting renewal premiums
3. Determining dividends.

**Initial Premium**
The insurance company underwriter establishes the initial premium for the group in all cases by basing it on the expected claims experience of the group.

For large groups, with around 200 or more employees to be included in health or life coverage, the premium will be set by the underwriter on the basis of standard tabular rates for the risk, plus consideration of anticipated changes and the employer's actual prior experience.

For small groups, with around 50 or fewer employees to be eligible for health or life coverage, the underwriter will pool the coverage. This means that this will be combined with other small cases to determine the premium. All the premiums from all the pooled employers are considered together and the premiums are based on the overall expected experience. They are then apportioned to each group according to its share of the pool.

If an insurance company, for example, took on a group policy for a firm with 20 male employees, all in their mid-forties and covered with $30,000 life insurance policies, there would be a probability according to actuarial tables that one man in 200 would die at that age.

Supposing the annual premium on the policy to be $3,100 and supposing that one of those 20 men should die, it would take the insurance company almost 10 years to recover the loss. But if the insurance company pooled the premiums of 10 such companies, and one man of the 200 covered were to die during the year, there would be enough premiums collected during that year to cover the loss with a little left over for expenses.

Of course in actual life the cases would not be so simple, since the covered groups would have a variety of ages represented and there would be other factors to consider, but this is the underlying principle on which pooling of risks operates.

**Credibility Factor**

In a case having too many covered employees to be fully pooled but too few to be fully experience-rated, an underwriter will apply a credibility factor. He takes the employer's experience as providing some predictability and partially pools the case. The extent to which the experience is meaningful, the type of risk involved, and other elements will enter into determining the figure for the credibility factor.

If an underwriter considers the prior experience of the employer to be of significant help in predicting what the future results of the case may be, he may assign a 40 per cent credibility factor to the case. Then the premium will be based 40 per cent on the employer's actual experience and 60 per cent on the experience of the pool.

If a case generated $200,000 in annual premium and a 40 per cent credibility factor was applied, 60 per cent of claims paid would be charged to the pool. Then if claims paid totaled $170,000, the charge for pooled claims would be $120,000 (60 per cent of $200,000), leaving a credit balance of $50,000 for the experience-rated claims.

If, on the other hand, claims totaled $230,000, the charge for pooled claims would still be $120,000 (60 per cent of $200,000), the charge for experience-rated claims would be $80,000 (40 per cent of $200,000) and the balance of the charge would be $30.000. Of this 60 per cent or $18,000 would be charged to the pool and 40 per cent or $12,000 would be the excess charge to the experience-rated group. Thus the pool actually would end up with $138,000 in claims and the experience-rated portion of the case would be charged with $92,000.

The underwriter will consider whether such good or bad experiences are likely to continue when he adjusts renewal premiums. If an employer has a better than average experience over a period of years, it will be to the advantage of the insurer to give him a good experience rating in order to keep him and help the overall experience of the pool.

The pool experience will be different from that of any one employer. The way in which cases are pooled can influence the amount of premiums paid by the employer. How a credibility factor is applied will depend on the nature of the risk and the historical experience of the group.

Some coverage such as long term disability or accidental death and dismemberment have a greater risk potential and may be pooled on a different basis from health and life coverage.

**Setting Renewal Premiums**

The underwriter at the end of the first year and usually each year thereafter evaluates the experience of the group and, if applicable, the pool. He assembles all the information he can in order to predict as accurately as possible what the experience of the group in the coming year will be. Trends and other factors will be considered in setting the premium for the year. If the experience of the group has not been as favorable as predicted, the underwriter must decide whether this trend is likely to continue.

It might be found in checking on causes of unfavorable experience that eligibility requirements were not strict enough and a disproportionate number of bad risks in the pool resulted. In this case it probably would be too late to change the eligibility requirements for existing groups, although they might be raised for new groups, and in order to allow for continued poor experience it would be necessary to raise premiums.

**Dividend Payments**
If a group insurance contract calls for payment of dividends, the underwriter determines whether one will be paid and if so, the amount. His calculations are based on the formula of the insurer and the experience of the group.

Payment of the dividend is based on actual experience rather than on anticipated experience as is the case in setting premiums, so the formula is different. An insurer might fully pool coverage for a small company with 25 employees and in that case the employer's premium would not be directly affected by his claims experience. But for paying dividends the insurer might pool only part of the experience of the same employer.

**Effects of Pooling**
A firm with several hundred employees will pay a group insurance premium reflecting the experience of those employees and their dependents, and nobody else. A small firm, on the other hand, whether it secures coverage through an association group plan, a multiple employer trust, or direct insurance, will have its risks pooled. For groups of 35 to 50 lives or more, only part of the risk usually will be pooled.

If the insurer is not maintaining a sound pool, the small employer can be at a definite disadvantage. If he is in a pool with a number of bad risks, even though his own experience is good, he can be pulled down along with the bad ones. For this reason the selection of the right insurance carrier is important.

The group package needs to be well designed, underwritten to minimize risks and abuses, and administered effectively. These three requirements are important to both large and small employers.

**How Plans Are Financed**
In recent years there have been considerable changes in the financing of group insurance plans. During the 1960s, most employers offered benefits that were fully covered by insurance companies or Blue Cross-Blue Shield plans. With the increased expense of health benefits during the 1970s, alternate methods of financing them began to be explored.

Large companies became interested in new financing mechanisms for employee benefits, and non-insured coverage and minimum premium plans began to come to the fore. From health plan financing this trend extended to disability and life coverage, and from large companies it filtered down to small ones. Some companies with a few employees changed their methods of financing health care benefits, sometimes from fully insured plans to substantially non-insured plans with some type of stop- loss arrangement in case of an unusual claim.

This trend can lead to complications in financing smaller plans because they may be part of a multiple employee trust, and in that case the trust, not the employer, is the policy holder. An employer could thus be participating in a trust that was self-insured without knowing it.

The fully insured plan is the most familiar arrangement in the operation of group insurance. There are others, however, and sometimes more than one approach may be used for the same plan. Alternatives were developed primarily to reduce the impact of premium taxes and reserves held by the insurance companies and thus to improve the employer's cash flow.

**Fully Insured Operations**
Under a fully insured plan, the insurance company may assist in designing the operation. After the plan is in place, the insurance company collects premiums and assumes the risk. The coverage may be pooled or experience rated, or offered through a combination of the two. Administrative services are provided and claims paid by the carrier.

Small employers who cannot absorb the risk of claim fluctuations find the fully insured plan the most suitable. It also appeals to employers who do not wish to have to become involved with administration and claims or to be forced to make a judgment on the validity of claims. Small businesses in such cases rely on the insurance carrier to keep them from having to complete eligibility information on claims forms.

**Fully Non-Insured Operations**
In contrast, under a fully non-insured or self-insured plan, the insurance company or service plan does not collect premiums or assume risk. The employer in effect is acting as an insurance company. He pays claims with the money he would be paying for premiums under a fully insured plan.

Employers with less than 1,000 employees generally will not have the financial or personnel resources for administering a fully non-insured plan and paying claims, and therefore will not find such a plan suitable for their needs. Insurance companies and independent administrators can be employed on a contractual basis to handle these functions, but their activities must be monitored carefully as they are handling and disbursing money belonging to the employer.

An employer unable to absorb fluctuations in claims should not adopt a fully non-insured plan. Severe financial loss can be suffered with a plan covering several hundred individuals if just one expensive claim has to be paid, unless a stop-loss arrangement is in effect.

**Minimum Premiums**
Some of the advantages of an insured plan can be obtained by the employer under a minimum premium plan. In this approach, there is an agreement between the employer and the insurance company that the employer will pay all claims until a certain aggregate level is reached, and the carrier will be responsible for claims above that amount.

The aggregate level usually is based on experience of claims paid within the past two or three years, adjusted by a factor allowing for inflation and greater utilization under the policy. The usual figure is 90 per cent of monthly expected claims to be paid by the employer and the rest by the insurer.

The claims are ordinarily paid by the insurance company using employer drafts up to the level agreed on and the insurer's funds after that point. If a company, for instance, had claims averaging $500,000 a month over the past two years and a 20 per cent trend factor was applied under the agreement with the insurance company, expected claims for the next year would total $600,000 a month. The insurer would pay claims up to 90 per cent of that total, $540,000, with drafts on the employer. Claims over that amount would be paid with insurance company funds.

The insurer under the minimum premium plan usually provides all administrative services. It must establish reserves for the entire amount at risk, not just the amount for which it has agreed to pay claims, because it is ultimately responsible for the entire risk if the employer should go out of business.

Usually there is some form of reserve reduction arrangement in such a case. Most insurance companies will not offer a minimum premium plan except to corporations with several thousand employees.

Advantages of the minimum premium plan to the employer are that it reduces the actual premium and the premium tax, provides protection against claim fluctuations, and lets the employer take advantage of the insurance carrier's claims expertise and other administrative services.

**Stop-Loss Insurance**
Unless a group has several thousand covered lives, it can be seriously affected by claim fluctuations. Stop-loss coverage is designed to take care of this problem. Although it is expensive, it reduces the group premium and premium tax, minimizes the need for the insurer to establish reserves, and provides protection against claim fluctuations and large unforeseen claims.

Stop-loss coverage usually is set up in terms of aggregate claims. The stop-loss carrier will pay the policy holder for claims after the aggregate amount agreed on of total claims by all employees and their dependents has been reached.

Another type of coverage known as specific stop-loss will pay on a per-case basis. This arrangement is similar to an insurance policy with a large deductible. Once the deductible is satisfied, the insurer is responsible for the balance of the claim. Depending on the nature of the contract, either the employer or the employee may be paid by the insurer in such a case.

In spite of its advantages, the stop-loss plan is not in widespread use among self-insured employers. It is expensive and often is offered only in conjunction with other arrangements such as the agreement to purchase group term life insurance.

**Large Deductibles**
Another way of easing an employer's cash flow problem that is similar to the stop-loss arrangement is the "big deductible" health plan. A number of small and medium-sized employers have adopted it.

Such a health plan uses a $500 or $1,000 deductible rather than the traditional $50 to $100. Usually the employer agrees to pay a portion of the deductible in order to keep his employees satisfied with the arrangement. If the previous health plan had a $100 deductible with 80 per cent coinsurance, for example, under a new "big deductible" plan the employer might continue to let the employee pay the first $100 while the employer would pay 80 per cent of the next $900.

The big deductible plan differs from the stop-loss arrangement in that the deductible is always assessed on a per-person basis, not on the aggregate claims the company has. Also the big deductible is an arrangement under a comprehensive major medical plan. A stop-loss approach is an addition to a self-insured comprehensive plan.

As with the stop-loss arrangement, under a big deductible plan someone will have to pay claims. The employer probably will not want to handle these details. Many insurance companies which sell big deductible plans will do so only to employers who use the claims services of an insurer or independent administrator.

The employer considering a big deductible plan needs to consider the cost of these services to be sure that the cost of paying claims does not exceed the cost savings on the policy.

To allow for inflation, the insurance company will have to increase its deductible by a percentage per year equal to the inflation rate plus an allowance for greater utilization of the plan. Unless the increased deductible is passed on to employees, the employer will not benefit from the change to a big deductible plan. Such a plan does, however, temporarily ease an employer's cash flow problem and it also has the advantage of involving the employer directly in the cost of health care coverage. The insurance company pool absorbs comparatively less of the employer's bad claims experience.

**Reserve Reduction;** Larger employers have found it possible to enter into agreements with insurers to reduce the amount credited on reserves held if the use of the money will give the employer an advantage because of the rate of interest available. Insurance companies are required to have adequate reserves, but through agreement the amount can be minimized on large group contracts. Such arrangements usually are used in connection with minimum premium plans. On an insured health plan reserves may be as much as 20 per cent to 30 per cent of the annual premium, and on life insurance plans about 20 per cent.

Under a reserve reduction agreement the most common procedure is to delay paying the premium for several months. The carrier might charge the employer interest for premiums paid later than the 30-day grace period, but this amount probably would be less than the value of the money withheld to the employer. Some employers use letters of credit, securities, or compensating balance arrangements, but laws and regulations in some states do not allow such procedures.

A retrospective rating agreement might be used by an insurer with a large employer. The insurance company and the employer would agree on a premium rate at the beginning of the contract year under this arrangement, and then if this rate proved to be too low the employer would make up the difference to the insurer. In this way the employer would have the use of the money until he repaid the insurer for the deficit.

The employer would be obligated to make up the deficit under such a "retro" agreement, whereas under a usual group contract if the rate set at the beginning of the year resulted in a large deficit for the insurer, the employer would have no obligation to make up the loss.
The "retro" arrangement is not practical for long term disability plans, under which insurance companies may set aside as much as 90 per cent of annual premiums for reserves.

**Limited Liability Plans**
The typical reserve for a fully insured long term disability (LTD) plan is five times the annual benefit. This can make the impact of reserves on policy cost quite substantial. Some insurance companies are now underwriting LTD plans under a limited liability arrangement.

The employer under this approach purchases one-year annual renewable LTD coverage. Reserves are only established for the duration of the contract, although claims are processed just as they would be under a fully insured LTD plan. At the end of the year or whatever the contract period is, the employer usually renews the contract and the insurer agrees to continue paying current claims and process new ones.

Under the limited liability arrangement, the initial reserve established by the carrier is substantially lower than for a fully insured LTD plan, and the liability for payment of the claim falls with the employer. The liability is not reduced, but the employer has the use of the money which he otherwise would have paid the insurance company for reserves under the fully insured plan. In some states this arrangement may not conform to insurance laws and regulations.

**Premium Waiver**
In the case of an employee who becomes totally and permanently disabled, under group term life coverage the insurer usually establishes a reserve against the eventual claim to be paid under the waiver of premium provision. Usually this reserve is equal to 75 per cent of the death benefits. It is held as long as the insurance company is responsible for the death benefit, which may be many years.

Sometimes larger companies in order to avoid losing earnings on these reserves will eliminate the waiver of premium provision from the life insurance coverage. The employer then in most cases continues to pay the premiums for the disabled individual as if he were an active employee. This practice is suitable for medium-sized and large employers who are not seriously affected by paying premiums for an individual who is not a productive employee. There may be a problem in this area with some state laws.

**Retired Life Reserves**
Most employers either continue to provide a portion of the active coverage on an employee when he retires, or terminate the entire group term life coverage. The employee may be covered for permanent insurance accumulated under a paid-up life or group- ordinary plan.

The employer who continues to provide life insurance for retired employees has a fixed liability in that eventually the retiree will die and the death benefit will be paid. The liability for the death benefit is established at the time the employee retires, and it is therefore logical for the employer rather than the insurance company to assume responsibility for this liability.

The death benefit could be paid from company funds, but some employers prefer to pre-fund their retired death benefit plans, especially in the case of a sizeable benefit. This is usually done through a trust or a paid-up life policy. Tax consequences in such cases need to be carefully reviewed.

**Enrolling Members**
Exact company policy must be followed in enrolling individual members and installing the plan. The principal forms needed are generally a master policy application, employee enrollment forms, and an ERISA (Employee Retirement Income Security Act) disclosure statement.

**Master Application**
The master application becomes a part of the official group contract and must be carefully filled out. It may vary with the kind of group insurance being offered. The employer or his authorized official and the sales representative must sign it to validate the contract.

The application must show the full legal name of the employer's business, the classes of employees to be insured, and the number of employees eligible to participate when the contract goes into effect. It also shows the type of coverage, waiting period before new employees are covered, and, if it is a contributory plan, the percentage of the premium to be paid by the employer and employee. If the plan is to replace

coverage by another carrier, this is shown. There may be other supplementary forms requiring additional information.

**Employee Enrollment Forms**
An enrollment form is to be signed by each employee who is to be covered under the group policy. The usual information required is the name, date of birth, occupation, date of employment, hours worked per week, annual wages or salary, and, when applicable, the beneficiary. A payroll deduction for part of the premium may be authorized by the employee's signature on the form.

**ERISA Disclosure**
Under the Employee Retirement Income Security Act (ERISA), it is required that commissions to be paid on group insurance are to be fully disclosed to the owner of the policy. The disclosure statement includes both first-year and renewal commissions to be paid to the agent. The insurance company provides a form to be signed by the employer and the agent, who keeps one copy and sends one to the home office.

**Other Forms**
When the group application goes to the home office, additional information may be submitted in memorandum form or in a cover letter, possibly giving the names of the contacts at the employer's business for policy changes or routine questions. There also may be supplementary forms, such as a replacement form giving information on former coverage if a previous policy is being replaced. Names of any employees who are disabled and drawing benefits under previous coverage would need to be included, as well as number of employees covered under the previous plan and names of those not covered. A copy of the replaced policy also should be included, along with the reason for replacement.

In addition to the master application, individual enrollment forms, and any other information needed, a check for the first premium is to be submitted to the home office. The employer who is sharing the cost of the group insurance with employees advances a check for the premium and then is reimbursed for the employees' portion through payroll deductions.

**After Delivery**
Delivering the master contract in person, the agent has the opportunity to review it with the employer and highlight the benefit provisions. Any points questioned by the employer can be explained with examples. Usually the insurance company provides printed instructions for the administrator of a group plan, giving reference on proper procedures and forms.

The administrator will handle new employee enrollments, reinstatements, conversions, claims, changes in amounts of coverage, changes of beneficiary, and other questions that may come up. The agent needs to be familiar with these procedures and go over the instructions with the administrator.

Along with the master contract, individual insurance certificates for employees will be delivered. Sometimes these certificates are included in booklets giving a summary of benefits, eligibility requirements, cost if any, conversion provisions, exclusions and other needed information.

**Servicing Contracts**
After the group insurance plan is in place, the agent customarily makes service calls to see that it is running properly and has met expectations. A good relationship offers opportunities to see if increasing benefits are needed or other kinds of coverage can be added.

Also there is always competition in the offing. Calls usually need to be more frequent in the first few months until a routine has been established. During each service call, the agent asks about new employees to be enrolled and any who may have been terminated. Name changes, beneficiary changes, and other adjustment need to be checked to see that the proper forms have been filled out and signed.

Pending claims, changes in individual employees' insurance amounts, and questions about premium payments may need to be discussed with the plan administrator, along with other details. It is useful for an agent to be able to check with employees who have resigned or been terminated with regard to converting their group policies to individual ones.

The need for increased benefits under the existing plan often comes up as salary levels increase and medical care costs rise along with prices in general. In the home office as a policy anniversary date approaches there may be a decision that a premium increase will be necessary. The agent needs to be able to prepare the client, assuring him that every effort will be made to keep the premium as low as possible and that he will be notified as soon as the actual figure is available. It is helpful to point out that a rate is guaranteed for a specified period and thus costs can be stabilized for that length of time.

The agent must convince the prospect that a well designed, comprehensive life, health, and disability employee benefit program will have a positive effect on employee morale, attract new employees because of its competitive coverage, and--if it is replacing a current policy--be priced competitively.

Information presented to a prospective group insurance purchaser should be suited to his needs after the agent has become familiar with the prospect's business operations and financial condition. The information should be arranged and emphasized in a way to fill the prospect's particular needs. It should include a complete description of all benefits and limitations in the plan, as well as a breakdown of rates and premiums for employees by type of coverage.

The policy itself should contain the necessary facts, which the agent needs to present clearly and concisely. Without discussing too many technicalities at once, the agent needs to take the course of answering questions as they come up.

In closing a group insurance sale an agent uses the same techniques as in closing an individual policy sale, going in with an assumption of consent, presenting the contract, and asking for the signature. What is needed at the end is the prospect's signature, along with a check for the first premium.

Group insurance basically is a concept that is easy to understand and it fills a need that most business owners recognize. Most employees now think of it as a condition of employment. The simplest and most popular of business insurance policies, it is an accepted idea which lets employers use money that would otherwise go for taxes to benefit themselves by attracting and keeping good employees with insurance benefits.

**RECAP**

Group insurance has gained growing acceptance with both employers and employees because it offers benefits to both. Employees can have insurance coverage at much less cost than they could secure policies individually. Employers benefit by recruiting quality people and keeping a stable work force. Both employers and employees can take advantage of tax incentives.

Life, health, and disability coverage can be offered through group policies. Life insurance on a group basis usually is offered in the form of term policies. The most common form of group policy has the employer making a contract with an insurance company and holding the master policy. Employees receive certificates and instructions for filing claims rather than individual policies.

Normally group policies are issued for one-year terms. At the end of that period the insurer reviews the claim experience and other factors to set rates and conditions for the next year. Because the risks are spread over a group and because the insurer is not locked in for a long period with respect to premium rates, costs are lower and selection standards less stringent than for individual policies.

The employer may pay tax-deductible premiums or costs of the coverage may be split between employer and employees. It is also possible in some cases that the insurer will offer combination group term and permanent insurance which employees can select at higher rates than the basic policies. For small firms special plans under IRS provisions such as Section 79 and Retired Life Reserve may be set up to meet pension needs.

Health and disability group plans are more complicated than those for life insurance. A third party, the care provider, is involved in addition to the employer and employee. Also the ever-increasing costs of medical care pose problems of financing.

A Health Maintenance Organization, or HMO, may combine the functions of care provider and insurer. Some corporations set these up for their employees. HMO patients are limited in the selection of doctors and hospitals to those associated with the HMO.

When an insurance company and employer contract to provide health care under a group policy for employees, the insurer pays medical bills for those covered as if they were being paid by the individuals, who can select whatever medical care providers they wish. Deductibles in the policy eliminate minor claims, and the size of deductibles has been increasing as a means of helping control costs of coverage. Some employer plans include dental care, though total costs of routine procedures may not justify the additional cost of premiums.

An order of coverage is established for those who may be eligible for medical care under more than one group policy. The primary policy pays first, up to its limit. Secondary coverage picks up additional costs up to its limit. Information for preventing over-insurance by coordinating coverage is required on policy application blanks.

As an alternative to group coverage by an insurer, the employer may choose self insurance, using money which otherwise would go for insurance premiums to pay claims directly. Unless the firm has 1,000 or more employees and considerable resources for meeting claims, self insurance is risky. With a small group, the employer has no way of forecasting the frequency of claims to be met or the amount of medical costs. One catastrophic illness claim under such an arrangement could result in disaster for the insurance program and even for the firm itself.

Professional and other associations, as well as unions, may provide group coverage for their members. A pool arrangement, which amounts to a group of groups, may give coverage to employees of small companies. In such a case a trust may represent the employers involved in signing a contract for insurance coverage and collecting premiums for the insurer. The claim history of the pool and resulting premium rates may be affected by one member with a bad record. It is even possible that an employer might become a member of a self-insured pool without knowing it.

An underwriter estimating risks for group coverage considers how large the group is and how similar its members are. Borderline cases of people who would not be covered under individual policies may be accepted for group policies to bring the volume up to the necessary level.

The main consideration for an underwriter in judging the nature of a group is whether its members have a pre- existing relationship, as employees, association members, or in some other way. If so, the insurer can be reasonably sure it is not simply a group of people banding together for the purpose of buying insurance. Such a group would have the potential for adverse selection against the insurer because of the number of individuals in it that could not get coverage otherwise.

# CHAPTER FOUR Disability

Although good health and long life are universal aims, illness and injury are always possibilities. Great advances have been made in medicine and in living conditions aimed at preventing or curing illness, but disability still remains a real threat. Statistically a person is more likely to become disabled than to die at a given age under 60.

The chances of disability are affected by many factors. These include the age, character, occupation, financial status, location, physique, and temperament of the victim. Disability varies from the minor irritation of a hay fever sufferer to the complete helplessness of a wholly paralyzed stroke victim. A hand injury that would be disabling to a concert violinist would not so seriously affect a banker.

**Social Consequences of Disability**

Disability is not a purely personal, individual thing, although it may seem so to its victim. The prosperity of organized society depends on the productiveness of its members. Unless protected by a provision for meeting the financial consequences of disability, a person changed by ill health from a producer to a large-scale consumer becomes a burden on all society. Thus disability and protection from it are of great general concern.

**Measurement of Cost**

Two principal elements make up the cost of disability. One is the loss of earned income or productiveness by the disabled person. The other is the expense involved in the provision of care made necessary by the disability. Both elements can be measured with reasonable accuracy.

The concept of earning ability as a capital asset is as basic to health insurance as it is to life insurance. The capital value of the human life can be destroyed by premature death or by disability through illness or injury. Life insurance guarantees the individual that his dependents will receive the discounted capital value of his life if he should die prematurely, and in the same way the value of the individual's earning power and the expenses of care can be guaranteed for the policy holder and his dependents by health insurance.

**Extent of Disability**

Surveys determining the extent of disability vary in results according to their methodology. The definition of disability and the time when the survey is made are also factors. Surveys have shown that up to five per cent of the population can be disabled at any one time. Each person suffers an average of one substantial and recognized illness a year. About half of these illnesses are disabling to the extent that work, school, or other activities are interrupted.

The average amount spent by a family in this country on medical care has been estimated in the past at four per cent of its budget. This proportion would be manageable for the average family, but the astronomical increases in medical costs since World War II and especially in the last 20 years have made some form of health insurance a necessity in meeting even average needs.

**Dealing with Risk**

Ways of dealing with risk include elimination, assumption, or transference. Elimination would be preferable, but there has not so far been found a way to eliminate the risk of disability. Most people are unable to assume the risk because of its universality and high cost, so they need to transfer the disability risk through insurance.

Substitution of certainty for uncertainty is the purpose of insurance. The individual transfers his risk of loss to an insurer. By pooling many individual risks the insurer is able to foresee a relatively certain and predictable loss for the entire insured group, although there is no way of telling which members of the group will be afflicted.

The disability hazard conforms for practical purposes, although not perfectly, to insurability specifications. An insurable hazard should be represented by a group of exposure units large and homogenous enough to permit accurate prediction of average loss by application of the law of large numbers. It must produce a

loss definite in time and place, a loss that is accidental, unexpected, and unpredictable by the insured in time and place. It must produce a loss that does not affect all or a large section of the insured group at the same time.

**Insurability of Disability Risks**
Within a practical framework of risk classification, the hazard of disability, while afflicting all mankind, is one that permits accurate enough prediction of loss to be susceptible to use of the insurance technique. Although less predictable and precise than death claims, health claims are still subject to approximate measurement.

Most illness and injury are unpredictable and not likely to be induced by the insured. Epidemics and catastrophic accidents vary the impact of disability from time to time and place to place, but if sufficiently large numbers of widely separated individuals are insured, the disability insurer is reasonably secure.

The disability hazard has proved to be insurable, but it has required underwriting ingenuity to make the coverage conform to sound, fundamental insurance principles. Most people want to be well, but there are malingerers, and caution is necessary.

**Contract Safeguards and Deductions**
The underwriter establishes contract conditions as a necessary protection. A typical exclusion clause denies benefits if disability is incurred because of illness existing at the time the insurance becomes effective. To discourage from securing insurance those who anticipate early disability, the contract sometimes incorporates a probationary or waiting period.

The deductible provision is an important consideration in the sound underwriting of health insurance. It eliminates from the payable benefits category losses that are minor, routine, and recurrent. Nearly all persons have some health care expense or suffer a few days of disability almost every year. To provide benefits covering such loss requires the insurer to collect the dollars that will inevitably be returned to the insured and, in addition, the relatively substantial sum necessary for the administration of claims for small amounts.

By eliminating the small loss from coverage, the insured's premium dollar is conserved to provide protection against the really insurable risk, the large, costly, and unpredictable disability.

**Coinsurance Participation**
An important device used by insurers to align the interest of insured and insurer is coinsurance or percentage participation. In health insurance the coinsurance clause requires the insured to bear some part of every element of the loss. In a contract to reimburse medical expense, the insured may be required to pay 20 per cent while the insurer pays 80 per cent.

To avoid tempting the insured to malinger by providing a loss-of-time benefit equal to earned income, insurers apply the percentage participation principle to loss-of- time benefits by insuring them for no more than 80 per cent of the insured's average income after taxes. The hazard of disability is insured successfully by underwriting ingenuity and conformance of contract provisions to fundamental insurance principles.

**Growth of Need for Disability Insurance**
People who lived simple rural lives relied for the necessities on their own brain and brawn, but as they began to live together in communities, absolute independence was replaced by interdependence. Each individual contributed the product of his special talent or skill. This trend was vastly speeded up by the Industrial Revolution.

At the same time, people living together in crowded environments were faced with new and considerable health and injury hazards. The former simple arrangements of the individual and family for caring for the disabled were no longer adequate in complicated modern society. Socioeconomic mechanisms developed to satisfy people's innate craving for security. In the United States, voluntary health insurance developed to fill this need. As the science of medicine progressed, the need for collective security such as that provided by insurance increased.

Life expectancy in America almost doubled in the twentieth century. This development resulted in more and more victims of the degenerative diseases of old age, as the infectious diseases that had affected young people were brought under control. Costly equipment and highly trained and expensive personnel also are required by the scientific progress of medicine. People also appreciate more the need for early and adequate attention to health problems.

All these forces have combined to make disability losses greater because of the rising cost of treatment. Inflation, higher taxes, and installment buying have made it difficult for most people to accumulate liquid savings or pay for disability expense out of current income.

Disability is a social as well as an individual problem. Thus organized groups in the community have become concerned with its increasing costs. Organized labor has made the provision of health insurance a major bargaining objective.

Government, always ultimately responsible for care of the indigent, has moved through Social Security disability benefits, Medicare, workmen's compensation and many other programs to improve the safety net for the general public.

General education to develop a wider appreciation of the importance of adequate health insurance has been encouraged by hospitals, physicians, and insurers, all of whom have a natural interest in the subject.

**Government Disability Benefits**

To be eligible for disability benefits under Social Security a worker must meet the requirement of being fully insured. For Social Security coverage this means the worker has paid into the system for at least 40 quarters--that is, has been employed and paid Social Security taxes for at least ten years.

The Social Security definition of total disability states that the person affected must be unable to engage in any substantial gainful activity "by reason of any physical or mental impairment which is expected to last for at least 12 months and/or end in death."

The amount of the disability benefit from Social Security is the worker's Primary Insurance Amount, which depends on the average earnings while working under Social Security. A waiting period of five months is required before the claimant can qualify for benefits. Time for processing the claim can mean it may be close to a year before the disabled person begins to collect benefits under Social Security.

Workers with job-related disabilities are eligible for benefits under workers compensation laws. These are now in effect in all states. Before the passage of workers compensation legislation, an employee injured on the job would have to prove in court that the employer's negligence had caused the injury. Workers compensation laws put the responsibility for expenses of occupational injury or illness on the employer without regard to proof of fault. Most though not all states require employers to carry insurance in order to be able to provide workers compensation.

Employees covered by workers compensation are paid a percentage of their wages before disability, usually two thirds of the wage amount. State laws place varying caps on the dollar amount to be paid. A few states provide benefits for nonoccupational disabilities.

Veterans receive benefits for disabilities incurred while on duty in any of the armed forces. These continue after the veterans leave the service, for as long as the total or partial disability lasts. The Veterans Administration is in charge of providing these benefits.

**Structure of Disability Policies**

For the large numbers of workers who are not eligible for coverage under Social Security, workers compensation, or VA benefits and for the even larger numbers who in case of disability would need more income than these programs provide, an understanding of disability coverage available in the private sector is important. Specific terms used in the policies have meanings which narrowly define the extent of coverage that will be provided.

**Earned Income**
The purpose of disability income insurance is generally to replace earned income. In a typical policy, income will be defined as salary, wages, fees, commissions, or other remuneration earned for services rendered by the person being insured. Whatever that person may receive from other sources, such as interest, dividends, rents, royalties, or other forms of unearned income, will not be covered since it is payable whether the insured person works or does not work.

**Total Disability**
The definition of total disability in a policy is important. Generally it is defined as the inability to perform the duties of one's own occupation, but a more restrictive definition can be inability to perform the duties of any occupation. Another definition of disability found in some policies is inability to perform the duties of one's own occupation for the first five years of total disability, and thereafter the inability to perform the duties of any occupation for which the policy holder is suited by reason of education, training, or prior economic status.

Obviously, it would make a major difference to the policy holder if the definition applied were stringent or liberal, depending on the extent of the disability and the individual's occupational requirements.

**Time Periods**
Two periods of time are specified in a disability policy. The elimination period is the length of time the policy holder must be totally disabled before benefits become payable. It may be expressed in days or months. The benefit period is the length of time the policy holder will receive benefits after disability payments begin. It may be a year or a period of years, or it may be to age 65.

**Accidental Injury**
Accidental bodily injury as defined in a disability policy usually refers to an unforeseen event resulting in injury. An accident which was not predictable and not due to a self-inflicted injury would be covered under this definition.

If the "accidental means" definition is used, the result is more restrictive. The cause or means of the accident must be unintentional or accidental in this case. A purposeful action by the policy holder that resulted in an unintended injury would not be covered under this definition. For example if a person who climbed out on a window ledge to watch a political demonstration were to fall off and break a leg, the resulting disability would not be covered. The prospective policy owner needs to be aware of the distinction in terms when disability insurance is being considered.

**Disability from Illness**
In the case of sickness resulting in disability, the policy usually refers to a condition which first manifests itself after the effective date of coverage. A pre-existing condition disclosed on the application for the policy may result in rejection or acceptance by the insurer. If the insured is accepted with the pre-existing condition which later causes disability, coverage would be in effect under the policy. The insurer also might issue a policy with a rider excluding benefits for the pre- existing condition.

**Types of Coverage**
A disability policy might offer occupational coverage, which would be in effect 24 hours a day, regardless of whether the illness or injury occurred on or off the job. A policy with non- occupational coverage would provide benefits only for illnesses or injuries not work-related. In such a case the policy holder probably would be covered by workers compensation or other employee plans. It is possible for employers to offer salary continuation plans as a fringe benefit for key employees, or group disability coverage under which employees can pay their own premiums through payroll deduction plans.

**Benefit Limits**
A limit to benefits under disabilities is set usually at a percentage of gross earned income that will not exceed the policy holder's net pay. This provision is made to encourage a return to work if possible and to avoid false claims.

**Residual Disability Income**
The definition of disability in traditional policies relates to job functions. It is possible to obtain a residual

disability policy clause which allows claims to be triggered by loss of income. Such a policy provision encourages a part-time return to work if the claimant is capable of it.

Under a traditional disability income policy, benefits stop if a claimant returns to work even on a part-time basis. A residual policy might offer benefits for a loss of 80 per cent of average pre-disability income if the policy holder could work enough to earn 20 per cent. Other arrangements are possible. Pre-disability income may be based on the previous year's earnings or on an average of the past two or three years or more.

Most such policies require the worker to be under a physician's care as long as the disability lasts. The pre-disability income under the policy is usually described as average income over a specified period of time.

Residual policies usually specify a qualification period as to how long a policy holder must be totally disabled before being eligible for benefits. In some policies this is in addition to the elimination period, while in others it may be substituted for by the elimination period.

**Form of Policy**

Like other insurance policies, the disability policy is a legally binding contract between the insurer and the insured. No verbal agreements or other documents can alter the contract after the policy, riders, amendments, and a signed and witnessed copy of the application have been examined and accepted.

The policy contains an insuring clause which defines the extent of the policy's coverage. A standard form covers mandatory provisions found in all health insurance policies. These include a statement on the time limit before the policy becomes incontestable. The insurer may not deny a claim or challenge any statement on the application after the policy has been in force for a stated period. The standard is two years, although some states allow three or four.

An exception to the incontestability period is made if it is discovered that a misstatement of age or sex appeared on the application. Usually this type of error will be discovered at the time a claim is made. It can be corrected and adjustments can be made in premium and benefit amounts unless it is found that fraud is involved. Fraud is the second exception to the incontestability limitation. It can void the contract at any time if proved by the insurer, provided there is a stipulation to that effect in the policy. Otherwise the fraud must be discovered and proved within the contestability period.

**Reinstatement**

A standard grace period is included in the policy to allow for a delay in premium payment before coverage lapses. The usual period is one month. A statement on the procedure for reinstatement in case of a lapsed policy must also be included. Usually the policy holder must submit an application for reinstatement and pay all back premiums with interest. Some companies will accept a signed statement of continued good health in place of the formal application.

The insurer is required to approve or disapprove the request for reinstatement within 45 days. If no decision is made by that time, the policy is automatically reinstated. Although accidents are covered immediately under a reinstated policy, there is a ten day probationary period in case of sickness.

**Claims Process**

After notification of loss, the insurer has 10-20 days (depending on the state) to respond to the insured about a claim. The period may be extended if the policy holder, for example, should be in a coma after an accident. Notification may be in writing or by telephone. The time it takes the company to get notified by the insured is all over the place, viz, incurred but not reported claims.

The claimant on receipt of the forms has a set amount of time (often 90 days) to complete them and file proof of loss. The forms will show the date and nature of the accident or sickness, along with names of doctors and hospitals providing treatment. A physician's statement about the probable duration of the disability is usually included. Further claims forms at regular intervals may be required for the duration of the disability to show that the policy holder is still unable to work.

**Settlement of Claims**

When the claim has been processed and clear liability established, the insurer is required to pay benefits

"promptly" under model provisions established by the National Association of Insurance Commissioners and adopted into law most states. "Promptly" means without delays which have occurred in cases of unfair claims practices. It is defined in a number of states as within 60 days of receipt of the claim.

A payment of claims provision in the policy identifies the person to whom benefits are to be paid. Usually a disability claim is paid directly to the insured unless an assignment form authorizes payment to a doctor, hospital, or another person. A Physical Exam and Autopsy provision allows the insurer to have a doctor examine the claimant at the company's expense for proof of a continuing disability.

An accidental death benefit clause is included in many disability policies. Under the physical exam and autopsy provision the insurer may request an autopsy to determine the cause of death if, for example, a policy holder dies in an automobile accident and there is a possibility that a fatal heart attack occurred before the wreck.

The legal action provision of a policy establishes a time period for resolving disputes in case of a disability claim. The insured under this provision cannot bring legal action against the insurer sooner than 60 days after proof of loss has been presented. In most states a maximum time limit for legal action, such as three to five years after a claim, also is set in the policy.

The final mandatory clause is the change of beneficiary provision, which gives the policy holder the right to change a beneficiary at any time unless an irrevocable beneficiary designation was made in the original policy. This provision is similar to the one found in life insurance policies, since health and disability policies may include accidental death benefits.

**Renewability**
Disability policies can contain various types of standard renewability provisions. A policy often issued for individuals in low-risk occupations, such as professions, is a non-cancelable contract. The insurer in such a policy guarantees that the contract cannot be cancelled and the premium cannot be increased.

A commonly issued contract is a guaranteed renewable policy. This is one in which the insurer agrees not to cancel the contract but does not guarantee the premium level. Policies usually are issued for one year. When the coverage comes up for automatic renewal, the premium may be increased.

An optionally renewable policy may be cancelled by the insurer or the premium may be increased on the anniversary of the policy or at the next premium due date. A cancelable policy, more rarely issued, allows the insurer to give written notice at any time that within five to ten days the policy will be cancelled or the premiums will be increased.

**Consideration**
The values exchanged by insurer and insured under the contract expressed by the policy are specified in the consideration clause. The insured provides the information on the application and the policy premiums. The insurer promises to pay the benefits set out under the policy.

**Free Inspection**
Under the standard free look provision the insured is entitled to inspect the policy when it is received and if not satisfied to return it to the insurer within ten days. In that case the premium paid will be refunded.

**Relapses**
Under the recurrent provision, if the policy holder is disabled again within six months of returning to work after a period of disability, for the same or related cause, the second incident of disability will be treated as a continuation of the first. Benefits in this case would be resumed without another elimination period.

**Premium Waiver**
Payment of premiums on the policy will be assumed by the insurer under the standard waiver of premium provision when the insured is totally disabled. After a waiting period of three to six months, the waiver of premium will be in effect and premiums paid during the waiting period will be refunded by the insurer.

**Optional Provisions**
There are several optional provisions in addition to the mandatory and standard ones which may or may not

be included in the policy. Their primary purpose is to protect the insurer. One is designed to avoid problems for insurers who operate in a number of states, some of which may have laws which conflict with provisions in the policy. To be a legal contract, the policy must conform to laws of the state in which it is written. The provision of conformity to state statutes allows the policy automatically to be considered amended so as to conform with all state laws in case there is a conflict.

An illegal occupations provision protects the insurer from losses due to claims resulting from criminal activities by the insured. An intoxicants and narcotics provision allows the insurer to deny a claim if an illness or injury is caused by consumption of alcohol or use of narcotics.

The unpaid premium provision states that the insurer may deduct from a disability claim payment any unpaid premium on the policy. Under the change of occupation provision, the insurer is to be notified if the policy holder changes to a more hazardous occupation in order for premiums to be adjusted for the higher risk. Proof of change to a less hazardous occupation would require a downward premium adjustment.

An optional provision allows the insurer to adjust premiums or benefits if it is discovered that the age or sex of the insured has been misstated in the policy application.

An average earnings clause is designed to prevent overinsurance on the part of the policy holder. The company establishes a limit to the amount of disability income coverage such as 70 or 75 per cent of the insured's earned income. On the application the prospect is asked to state if other disability coverage is in force, and if so the amount. Also, if the insured's income has decreased between the time of the application and the time of onset of disability, the proportion of earned income covered may be above the company's limit. In that case benefits would be reduced and a pro rata refund of past premiums paid on the higher coverage would be made.

Thus there are three types of provisions in a disability coverage contract. Twelve are mandatory and are found in all health insurance policies including disability. In addition there is a group of standard provisions customarily found in disability policies, and finally optional provisions permitting adjustments to protect the insurer.

**Residual Income Policies**

Under the conventional disability policy, benefits stop as soon as the insured returns to work even part time. After a period of total disability it is common for the recovering patient to be able to work for a short period at first, then gradually increase employment hours until returning to full time. To encourage this activity, residual disability policies are offered.

Residual policy benefits depend on loss of income rather than loss of ability to do any work. The amount of the benefit depends on the loss of pre-disability income due to the disability. A person able to work enough to earn 10 per cent of average pre-disability income would receive 90 per cent of the total disability benefit under a residual policy. Benefits are continued in proportion to the insured's loss of income. This arrangement offers an incentive for a person to return to work rather than prolonging the total disability period.

A qualification period is included in most residual disability income policies stating the amount of time the insured must be totally disabled before becoming eligible for residual benefits. The pre-disability earnings on which residual benefits are based may be the amount earned during the year preceding the disability or may be an average of two or three previous years.

**Optional Benefits**

Various optional benefit provisions may be added to disability policies for additional protection. One is the presumptive disability benefit which recognizes as total disability the total and irrecoverable loss of sight in both eyes, hearing in both ears, ability to speak, use of both hands, use of both feet, or use of one hand and one foot. This provision is like the accidental death and dismemberment clause in life or health policies except that it requires only loss of use, not actual loss of hands. Usually in presumptive disability cases the insured is not required to be under a physician's care during the total disability period as in most disability coverage.

A transplant and cosmetic surgery benefit may be added to a disability policy, which normally would not

cover voluntary surgical procedures. This optional benefit would make it possible to receive benefits while recovering from cosmetic surgery or from surgery for voluntary donation of an organ in a transplant procedure.

A rehabilitation benefit may allow total disability benefits to continue while the insured is actively participating in a training program to make it possible to work in another field. A lump sum for vocational training may be provided by the insurer for approved vocational training. This option helps make it possible for the insured return to work even though in another field from the pre-disability occupation.

A future increase or guaranteed insurability option allows the insured to increase disability protection at option dates regardless of insurability, in order to keep up with increases in income. Limits are set on this option to avoid overinsurance.

A cost of living benefit automatically increases the monthly disability benefit of the insured while a claim is being paid. The increase may be a fixed percentage or other factor related to a consumer price index.

To allow for non-coverage by Social Security, which denies about two out of three disability claims, two types of riders may be attached to a disability policy. One is an all or nothing rider, under which the policy pays benefits if Social Security does not, or pays nothing if Social Security coverage is allowed. The other is an offset rider under which the policy benefit will be reduced by the amount of whatever benefit is provided by Social Security.

An additional monthly benefit rider will provide short-term benefits during the first six months or a year of disability while the insured is waiting to obtain Social Security benefits. This type of rider also may provide benefits for additional coverage under a short-term group disability policy provided by an employer.

A hospital confinement rider will pay benefits on a total disability basis while the insured is a hospital in-patient. Otherwise an elimination period would be necessary before the start of disability benefits. A non-disabling injury rider will pay medical expenses incurred because of an injury that is not totally disabling. All these optional benefits are designed to increase the overall protection offered by a policy and help meet special needs of the insured.

**Factors in Disability Programs**

In developing a suitable disability program for a prospect, an agent needs to be aware of the total financial needs of the client as well as his qualifications and ability to pay for the coverage.

A longer elimination period, like a larger deductible on an automobile policy, reduces the cost of the premiums. A policy with a 60-day elimination period costs approximately 20 per cent less than one with a 30-day period.

The client needs to consider how long it would be possible to wait for disability benefits to start in view of fixed obligations and other expenses, taking into consideration savings or other liquid assets that would be available. The possibility of work related benefits and Social Security or other statutory benefits should be considered in determining the length of the elimination period selected.

The length of the benefit period is the next consideration. The longer the benefit period is, the higher the cost of the policy will be. Benefit periods usually may be chosen as one, two, or five years or to age 65. A lifetime benefit period also is available as an option, but at a higher cost.

The benefit amount selected usually is expressed in terms of a percentage of gross earned income, such as 70 or 75 per cent. Existence of other disability coverage and amount of unearned income also will play a part in the benefit amount allowed by the insurer's limits. These are set to avoid overinsurance and the consequent lack of an urgent need to return to work on the part of the insured. The net worth of a prospect also is considered in determining benefit limits. An extremely wealthy person ordinarily would not be considered as a prospect for disability insurance.

The addition of optional policy benefits to a standard disability policy would depend on the prospect's ability to pay and special needs. Company practices vary, with some including as standard benefits provisions which are added as optional riders by other insurers. The expense of most riders is not large, ranging

somewhere between $30 and $100 a year, but the prospect's needs and ability to pay have to be considered in designing the individual policy.

**Business Policies**

Group disability income policies can fund sick pay plans for employers and employees which can be designed to qualify for tax advantages under Section 105 of the Internal Revenue Code.

A sick pay plan to be tax deductible for a corporation in effect before the disability begins, must be in writing as part of the corporate minutes, and must be communicated in writing to the employees. With such a formal plan in effect, premium payments are tax deductible as necessary business expenses. Benefits received by employees are taxable to them. If employees pay part of the premiums, a proportional part of the benefits is tax free to them.

For non-incorporated businesses, premiums are tax deductible for employees and sole proprietors or partners may deduct 25 per cent of the amounts paid for health insurance.

If a key employee becomes disabled, payments made under an established salary continuation agreement are tax deductible for the employer. Unless the agreement is funded by insurance, however, the employer is obligated to pay disability benefits out of company funds. If a disability policy covers the arrangement, the employer pays tax-deductible premiums in an amount that can be known ahead of time, unlike an unforeseen, unfunded disability. The insurance company then is responsible for making the disability benefit payments.

A formal sick pay plan makes it possible to attract quality employees and keep them by making them feel financially secure through protection against disability from illness or accident.

Under most group disability income plans, short-term coverage is provided. Elimination periods are usually 30 days or less, and the benefit period is from six months to a year. Such policies are planned to offer coverage until Social Security benefits for permanent disability begin.

In a long-term disability group plan, an elimination period of three to six months is usual. The benefit period is for two years, five years, or most often to age 65. The amount of benefits is limited to a percentage of the insured's earned income. Usually benefits are integrated with those from another employer plan, workers compensation, or Social Security, in order to prevent overinsurance. Disability programs are not designed for the insured person to make money off benefits.

Either short term or long term group disability policies can offer occupational coverage, which includes both job related and non-job related disabilities, or non- occupational coverage, which applies only to disabilities caused off the job. The non-occupational coverage is used when job-related disabilities come under workers compensation or similar plans.

If a group disability policy is paid for by the employer, benefits are taxable to the employee. Some plans may be set up for employees to pay all or part of the premiums on a payroll deduction plan. In that case, the proportion of benefits paid for by the employee's contribution will be tax-free.

Under a group disability contract, usually there is no requirement for the participating employees to prove insurability. Thus it is possible for an individual who otherwise would be uninsurable to be covered for disability benefits. Also rates are lower than for individual policies. In the case of an occupation that would be rated as higher risk than average, the group rates could be a valuable consideration.

The disadvantage of a group disability policy is that the policy is owned by the employer, who can terminate it. Also if an individual changes jobs, his disability coverage with the original job will be lost.

Professional associations may offer group disability plans for members. These will have standard elimination periods, benefit periods, and benefit amounts, with premiums increasing as the insured person moves up through specified age groups. Such a plan is an advantage for an association member who might otherwise be uninsurable. The insurer may raise premiums, however, or the association may cancel the plan. Also, the insured usually must maintain membership in the association to keep the coverage.

**Overhead Expense Policies**
A special disability policy designed for small firms which might have to close for a time if the owner were disabled is the Business Overhead Expense policy. The contract provides coverage based on the average overhead expenses of the business if the owner is disabled. Employees' salaries, rent, utilities, and other expenses are covered by benefits paid to the business, not the owner, under the policy. The owner's salary is not included. The arrangement makes it possible for the business to be kept as a going concern until the owner is able to return.

Usually the elimination period is 15 to 30 days and the benefit period is one to two years. Premiums paid on the policy are tax deductible to the business, and although benefits received are taxable, they are used for deductible business expenses.

**Key Person Insurance**
When a key employee becomes disabled, a business can be protected through a disability plan similar to key person life insurance.

The policy is designed to provide benefits to the business to make up for the loss in income it will suffer through key person disability. The business will own the policy and pay the premiums, which are not tax deductible, but it will receive the policy benefits tax free as the beneficiary.

**Buy-Sell Agreements**
Life insurance policies can be used to arrange for continuity in management through buy-sell agreements between partners or officers in a close corporation. Buy-sell funding through disability insurance can be even more important. In case of a permanent disability on the part of one of the business owners, funding will be available so the business can purchase the interest of the disabled owner. The family of the disabled person will receive the previously agreed-on value of the business interest and the business can continue uninterrupted operation.

Usually such an arrangement is made through an entity purchase agreement under which the business buys and pays premiums on the disability policies covering the owners. The premiums are not tax deductible, but benefits received by the business as beneficiary in case of disability of one of the owners will be tax-free. They can be used for a lump sum or installment buy-out of the disabled person's interest of the firm.

This arrangement has the advantage of assuring that ownership will remain with the active operators of the business. It guarantees that a competitor cannot buy out the interest of the disabled person. Also an unqualified family member cannot come in to take over a share in management.

The value of the interest, length of elimination and benefit periods, and definition of permanent disability are established in the policy provisions. Review and revision of the value of the business interests owned by covered individuals are provided for over set periods of time.

There are advantages in the equity buy-out for the person who becomes disabled. A set value and guaranteed market for the liquidation of the business interest are provided. Possible losses by the business after the buy-out will not be a liability to the disabled person. Family members will not be forced to enter the business to support themselves.

In the case of only two or three business partners, each may take out a disability income policy on the other partners or shareholders in a cross purchase agreement instead of an entity agreement in which the business owns the policies. This arrangement can require a number of policies if there are several owners, and each is individually responsible for keeping up the premiums. For four or more principals, an equity agreement is more manageable.

The elimination period for a buy-out disability policy usually is one or two years to establish that the insured is totally disabled and can be expected to remain so. A long elimination period also lowers the cost of the policy.

In a policy providing for installment benefits, it is possible to provide that payment of the last installment will

trigger the implementation of the buy-out provision. If the insured recovers and returns to work before that time, no buy-out has occurred. Benefits that have been received are taxed to the business as income and the firm goes on as before.

**Underwriting Procedures**

In the home office of an insurer, the applicant for insurance is known as the risk. The decision on whether or not to accept a specific risk is up to the person in the office known as the underwriter.

Pertinent information on the risk is received and funneled to the underwriter, who reviews and evaluates it before deciding on whether a policy should be issued and on what terms. Decisions on disability risks are on a somewhat different basis from those for life insurance policies. If an applicant has a bad back, he is more likely to be disabled from it than to die from it.

The agent who sees the insured in person is responsible for obtaining accurate information as the application for the policy is being prepared. Age, sex, and occupation of the applicant are the major points to be considered by the underwriter, along with medical history, family history, current physical condition, and information on other insurance owned. The agent in a separate report may comment on the prospect's appearance, surroundings, indications of moral character, length of time the agent has known the applicant, knowledge of any unusual or hazardous hobbies, and details of duties involved in the occupation listed.

Occupations are grouped by insurers into classes according to the hazards they pose. A background check may determine whether the prospect's record would indicate the possibility of a moral hazard such as would be involved in filing a fraudulent claim. A medical examination may be required if the prospect's history or current condition is believed to warrant further investigation.

Financial underwriting considers all sources of the applicant's income, earned and unearned, as well as total net worth. Other sources of disability income insurance are also considered in guarding against overinsurance. Most companies will provide coverage for 60 to 70 per cent of earned income. Total net worth and liquidity of assets are considered to determine whether the individual actually needs disability coverage.

If a risk is sub-standard, a higher rate may be charged or the elimination and benefit periods may be adjusted to compensate for medical conditions. Riders also can be added to the policy to exclude already existing conditions or to exclude coverage for known medical problems for a specified period of time.

Group disability policies usually are written without information on individual medical conditions provided the group is of the required size. A plan maximum for benefits may be $1,000 to $2,000 a month, or not more than 70 per cent of the employee's earned income. The insurer may guard against adverse selection or hazardous occupations by offering only non-occupational coverage, which would not include disabilities that were work-related.

Association coverage amounts to individual policies handled on a group basis. Usually a few medical questions are asked, but depending on the size of the group, minor problems may be overlooked. The amount of coverage and length of elimination and benefit periods are limited in the agreement with the association.

**RECAP**

The ability to earn an income, the average individual's major financial asset, is protected by disability income insurance. The concept is important because, statistically, economic death due to disability is a higher risk than dying during the income earning years. Life insurance is no guard against economic death.

To be eligible for disability benefits under Social Security a wage earner must have 40 quarters of FICA coverage, and total disability making any gainful employment impossible is required. Workers compensation benefits cover only job-related disabilities.

In disability policies, the elimination period is the length of time the insured must be totally disabled before benefits start. The benefit period is the length of time benefits will be paid. "Disability" may be defined as the inability to perform the duties of one's own occupation, or more restrictively, the inability to perform the

duties of any occupation. To avoid over- insurance and encourage a return to work as soon as possible, disability benefits usually are limited to a percentage of the insured's gross earned income not to exceed the net pay.

An insurance policy is a legally binding contract between the insurer and the insured. Disability income policies contain the same mandatory policy provisions found in other health insurance policies. They cover the subject matter of the entire contract along with specific statements about the incontestable period, grace period, reinstatement, claims process, legal action, physical and autopsy provisions, and designation of beneficiary.

Other standard provisions specify policy exclusions and renewability conditions. In a guaranteed renewable policy the insurer guarantees that the contract will be renewed but does not guarantee the premium, which may be increased on the policy anniversary. Under a non- cancelable policy both the renewability and the premium are guaranteed. An optionally renewable policy may be renewed at the option of the insurer. A cancelable policy, seldom used in disability insurance, can be cancelled or the premiums increased at any time at the option of the insurer with five to ten days' notice.

Optional provisions also may be added to a disability policy. They include safeguards including the relations of earnings to benefit limits to protect against overinsurance and a change of occupation provision allowing the insurer to adjust rates if the insured enters a more hazardous occupation than the original one.

A residual disability policy offers an incentive for the insured to return to work as soon as possible, even if only on a part-time basis. While benefits under a traditional disability income policy stop if the insured takes on even part-time work, residual policy benefits are determined by the amount the insured is able to earn as a proportion of pre-disability income.

A qualification period in a residual disability policy specifies the amount of time the insured must be totally disabled before qualifying for residual benefits. Some policies combine this with the elimination period before disability benefits start. Average pre-disability earnings as the basis for the residual claim may be those over the past year or over a period of two or three years.

Optional provisions to meet specific needs of the insured may be added to disability income policies or residual policies. A lifetime benefit rider may extend coverage beyond the normal limit of age 65 to the lifetime of the insured. Disability due to an accident normally will be covered under such a rider if it continues through a lifetime. Sickness benefits under the lifetime benefit usually are scaled down to a percentage of the full benefit received before age 65.

A so-called Social Security rider or additional monthly benefit rider may be added to a policy as a short-term benefit designed to cover the insured until Social Security benefits can be secured. Also an all or nothing rider will pay benefits if the insured does not qualify under the Social Security definition of disability. Under an offset rider the policy benefits will be reduced or offset by any Social Security benefits. A cost of living benefit rider will provide for an increase in benefits by a factor related to a consumer price index. A future increase option allows for purchase of additional coverage. Cost of riders and adjustments in length of elimination and benefit periods need to be considered in designing individual policies suitable for prospects.

In business, disability policies may offer even more important benefits than life insurance policies. Group disability insurance for employees usually is provided without medical examinations. Insurance for businesses may meet overhead expenses during an owner's disability.

Entity purchase or cross-purchase policies will protect a firm from disruption in case of the disability of partners or close corporation officers. If properly structured, business policies can have tax advantages.

# CHAPTER FIVE Annuities

An annuity is not classified as life insurance, as it provides no insurance protection. It is, however, issued by life insurance companies. The annuity buyer might be compared to a person who buys a house with no intention of living in it. The house in this case is an investment to produce income in the form of rent.

The basic purpose of an annuity is to distribute a regular, guaranteed lifetime income through a scientific liquidation of invested capital. Life insurance also provides for liquidating capital in death proceeds or cash value over a lifetime, but the fundamental purpose of life insurance is to create capital at death. An annuity provides for lifetime income.

A life insurance company can accept a certain amount of capital and guarantee that it will pay a specific lifetime income to the annuitant (the person who is to receive the income) because life insurance companies have accurate, scientific methods of predicting the annuitant's length of life.

Annuity tables have been developed based on the law of averages and the record of life spans compiled over generations. Some annuitants, of course, will die sooner than expected and some will live longer, but the company's annuity transactions will work out on the average over a period of years.

**Basic Risks**

In the final analysis, an individual faces two basic risks, those of dying too soon or living too long. Life insurance is concerned with the creation of an estate. In case of premature death on the part of the policyholder, an estate is left for the survivors because of the pooling arrangement of many individuals' funds to benefit the few who die before their time.

Those who live long, on the other hand, can benefit at the expense of those who die early through the use of annuities, which amount to life insurance in reverse.

**Annuity Purposes**

The original meaning of "annuity" was an annual payment. Now annuities come in many different forms and can be paid at a wide choice of intervals. An annuity is an appropriate choice of investment for people who have no dependents and expect to have none, or who have already made provision for survivors' coverage and need only to consider their own old age income.

Annuities also provide a good solution to the problems of uninsurable individuals who do have responsibilities for dependents. With annuity payments they can set aside substantial amounts regularly. If they die, their families will receive at least the sum total of the annuity premiums and probably much more from interest earnings.

Retirement income needs can be met with one of the forms of permanent insurance, but even in high premium types a portion of the premium must go to pay for current insurance protection. Only the remainder can go into the reserve, from which cash values and equivalent annuity incomes are paid out. If death protection is not needed, all the money can go into the purchase of annuity income.

These are some of the individuals for whom annuities may be the best solution-

- A middle-aged to elderly person who has inherited a substantial sum of money, has no dependents, and is concerned about using funds from principal.
- A career person who makes good money and wants to quit working at an early age, or realizes that age and business pressures may force retirement.
- A person who has unusually large earnings in a relatively short period, such as a sports professional, an actor, or an entertainer.

**How Annuities Work**

It may be difficult for a prospective annuity buyer to understand how an insurance company can promise to

pay out more than is being put into an annuity in its early stages if that buyer is used to thinking in terms of a savings account or certificate of deposit. In these cases the account owner gets back just what was deposited plus whatever interest has accumulated. In these cases also, the federal government insures the deposits.

Annuities draw on a pool created by many investors, making it possible to provide more flexible returns, but they are not backed by federal insurance. For that reason it is important to be sure of the stability of the issuing institution. Annuities may be purchased not only from insurance agents but from banks, brokers, financial planners, or mutual fund companies, and no annuity is any safer than the firm that issues it.

Nevertheless annuities increased greatly in popularity with changes in federal tax laws during the 1980s. Since then, the sales of both fixed and variable annuities remain strong. Between 1989 and 1999, the American Council of Life Insurers reported that premiums on annuities more than doubled from $49.4 billion to $115.6 billion. In 2015 premiums from annuities amounted to $324 billion.

The big advantage in an annuity is that income taxes on investment earnings are deferred until the accumulated earnings are paid out. In the case of a long-term annuity the investor may well expect to be in a lower tax bracket at collection time than at investment time.

Also it is possible to put as much as the investor can spare into an annuity, while Individual Retirement Accounts are limited to $2,000 a year or less depending on the taxpayer's pension status. An annuity can run to hundreds of thousands.

**Development of Annuities**

The use of annuities to pay out estates in annual installments is not a new idea. It is believed to have been used in the Babylonian Empire of Nebuchadnezzar II, which had well developed banking and commercial facilities.

The first recorded annuity system is the Falcidian Law of 40 BC during the Roman Empire, which set regulations for paying out specific legacies. A rough system of mortality estimates was used, calculating that an annuitant up to age 30 could expect 30 more years of life, and one older than 30 could expect whatever number added to his age would equal 60. Not many people in those days lived to be older than 60.

A refinement of this system was produced by a Roman judge about 200 AD. The foundation of scientific annuities and modern life insurance tables, however, did not come until 1771 in England with the publication of the "Northampton Table of Mortality" by Richard Price. Refinements and adaptations were added over the next two centuries with the development of actuarial science.

The annuity was a more popular investment in Europe than in America until the Depression years of the 1930s, which brought to wide attention in this country the need of a secure investment for liquidating principal.

**Kinds of Annuities**

People who had any assets left during the 1930s were primarily concerned with finding an investment that would yield an unfailing fixed dollar income. That need was filled by the conventional or fixed annuity, which provides for payment of money in fixed installments over a time period. Each payment represents part interest and part principal. The combination makes possible a greater return over the annuitant's lifetime or chosen long-term period than other safe investments.

Postwar inflation brought changing needs for investors. You could put a stack of $100 bills away in a safe deposit box and depending on how long you left them there they might be like a stack of $20 bills in buying power when you or your heirs took them out.

Beginning in the 1950s, a new type of annuity designed to cope with inflation was developed. Called the variable annuity, it yields income on the basis of investment results. The first variable annuity on the market was designed by the Teachers Annuity and Insurance Association and appeared in 1952 as the College Retirement and Equities Fund (CREF).

**Annuity Terms**
Under the two major divisions of fixed and variable annuities there are a number of sub- classifications. There are pure and refund annuities, immediate and deferred payment annuities, single premium and periodic premium annuities, and annuity contracts covering one or more lives.

The general definition of an annuity is a contract between the company issuing it and the person buying it in which the purchaser agrees to pay the issuing company a certain amount of money in exchange for a regular income over a specified period. The time period may be the individual's lifetime or an exact number of years.

According to the plan of distribution, the contract may be a straight life or a refund annuity. A straight life or pure annuity pays the largest outcome for a given premium. Thus it guarantees the annuitant maximum income for life in proportion to the amount of money invested.

Straight life annuities are not as frequently issued now as formerly because no matter how many or how few benefit payments have been made; the death of the annuitant ends the obligation of the issuing company. More buyers prefer the refund annuity.

If an annuitant dies before the income has begun, a refund annuity provides for the return of premiums paid, in some cases plus interest. If the death of the annuitant occurs after income payments have begun, a refund annuity with an installment payout arrangement can provide a certain minimum number of payments whether or not the annuitant dies before the payments are made.

If a person at age 65 buys a life annuity with a guarantee of 120 monthly payments, and dies after 60 payments have been made, the named beneficiary will continue to receive monthly payments for five more years.

An installment refund life annuity can provide for payments to continue until they equal what was paid in for the annuity in case the annuitant dies before receiving that amount. If a man who purchased a $20,000 annuity which was scheduled to make payments of $100 a month should die after 120 months (ten years) his named beneficiary would continue to receive the $100 monthly payments for another 80 months until the full purchase price had been returned.

A 50 per cent installment refund annuity is offered by some companies at a larger payout than the 100 per cent refund type. Cash refund life annuities will give a single payment when an annuitant dies, equal to the difference between what was paid for the annuity and the total of annuity payments received before death. If $15,000 had been received on a $20,000 annuity, the balance of $5,000 in this case would be paid to the beneficiary in a lump sum.

Annuities with refund provisions cost more than pure annuities, but for younger buyers the difference is less than for older buyers.

**Annuity Terminology**
Annuities are structured through the use of life insurance mortality tables, and insurance terms generally are used in describing them. Payments made for annuities are called premiums. They are not, however, like life insurance premiums that are required for keeping the policy in force. Annuity premiums, like money deposited in a savings account, earn interest. They may be made on a flexible schedule or all at once in a lump sum. The annuity premiums are invested by the issuing company in order for them to increase in value. The annuity contract states what interest rate will be paid for what period.

A rate may be guaranteed for one to five years. The contract may call for the rate to be reviewed at specified intervals after that time. The rate paid on Treasury bills is often used as an index for setting annuity interest rates. Cost-of-living calculations also may be used. The issuing company guarantees a minimum interest rate, typically of three to five per cent.

Usually there are charges for sales commissions, and there are surrender charges on withdrawals exceeding ten per cent of the accumulated investment. Also the tax- deferred advantage for accumulated interest is lost and a ten per cent tax penalty imposed on earnings is charged in case of withdrawals. For

this reason an annuity is not suitable for a short-term investment. A minimum of five to fifteen years before withdrawals may be necessary to avoid loss.

As in insurance, the buyer of the annuity is called the owner. The person who is to receive the payments is the annuitant, who may or may not be the contract owner.

Many measurement situations in financial transactions involve periodic deposits, receipts, withdrawals, or payments (called rents); with interest at a stated rate compounded at the time that each rent is paid or received. These situations can be treated as annuities for computational purposes if all the following conditions are present:

1.) The periodic rents are equal in amount
2.) The time period between rents is constant, such as a year, a quarter, or a month
3.) The interest rate per time period remains constant
4.) The interest is compounded at the end of each time period.

**Payment Options**

According to the time payments begin, annuities are divided into immediate and deferred types. With an immediate annuity, payments to the annuitant start soon after the purchase date, at the end of an agreed payment period which may be monthly, quarterly, semiannual, or annual.

Someone who has sold a house, for instance, and wants to provide for a regular income in exchange for a cash investment could buy an immediate annuity in order to have income payments starting within a month and continuing for years or a lifetime, depending on the terms of the contract.

For a deferred annuity, a future date on which payments to the annuitant will start is specified in the contract. The time between the purchase of the annuity and the maturity date is known as the accumulation period, and the period after the maturity date, during which the annuitant receives payments, is called the annuity, liquidation, or distribution period. The schedule in the contract determines the timing and length of the deferred annuity payments.

A typical purchaser of a deferred annuity might be a middle-aged man wanting to provide for economic security after his retirement. He wants an additional income besides Social Security and his company's pension plan. A deferred annuity that will begin to provide him with a regular income at age 65 can be purchased either with a lump sum payment or with a regular schedule of payments up to the time he reaches 65.

After a decision is made between an immediate and a deferred annuity, there are other options to be considered. There are premium options, settlement options on the method and frequency of payments to the annuitant, options on number of lives to be covered by the contract, and surrender terms setting out how the owner can terminate the contract before maturity.

**Options on Premiums**

Either an immediate or a deferred annuity may be purchased with a lump sum. The purchaser makes a single payment of whatever minimum amount the issuing company will accept, such as $10,000 or $20,000, or a much larger payment according to the customer's wishes.

For a purchase on the installment plan, only a deferred annuity is available. The buyer may select monthly, quarterly, semiannual or annual payments to continue on a regular schedule until the date of maturity when benefit payments start. This option fits in with a familiar habit for investors who have been accustomed to making regular savings account deposits.

Also available for deferred annuities is a third payment option, the flexible payment annuity. Under this arrangement the timing and amount of premium payments can be varied. Prospective annuity buyers who have irregular incomes such as commissions may need a program in which they can vary the amounts they save every year. Families with growing children also may need flexibility to take care of changing or unexpected needs.

An annuity contract might be purchased with a minimum deposit of $2,500 and continue to accrue interest even if no further payments were made. Some companies now will sell an annuity contract with an opening

payment as low as $250 and flexible premiums for future years.

**Options for Settlement**
The way in which funds from an annuity are to be distributed is known as a settlement option. The issuing company and the annuity owner agree on what this option will be, usually choosing one of four major types.

The lump sum settlement is to be paid in its entirety at the date the annuity matures. The settlement includes both what the owner paid in premiums and the interest earned by the funds.

An interest-only settlement will pay the annuitant the total of interest earned, leaving another settlement option for a later date.

The owner may choose to have the settlement paid in a certain number of payments or a certain dollar amount over a number of years. Quarterly checks for equal amounts might be paid, for example, over a ten-year period.

Probably the most familiar settlement arrangement for annuities is the life income option, under which the annuitant receives payments until death. Payments may or may not continue after that point depending on contract arrangements. A straight life contract provides for guaranteed payments at a selected period which will end when the annuitant dies. No remaining balance is paid to a beneficiary or the estate of the annuitant.

If a man who purchased a straight life annuity to begin paying him a regular income when he reached 65 lived to be 100, the company that issued the annuity would pay him until that time. If he died at age 66, the payments would stop at that time. Thus the straight life annuity does not guarantee that the annuitant will receive payments equal to the amount paid as premiums on the contract. On the other hand, if the annuitant dies during the accumulation period, proceeds will revert to the beneficiary or to the annuitant's estate if no beneficiary has been named.

Because of the limit on payout, the straight life annuity option gives the highest income per dollar of premiums among all types issued.

**Period Certain Options**
If a buyer does not want to use the date of death as a settlement date, preferring not to gamble on whether the owner or the issuing company will make a profit, the choice may be a period certain or refund option annuity. These guarantee a minimum amount that a company will pay on an annuity.

These options amount to types of death benefits, providing for a payment to be made to designated beneficiaries when the annuitant dies. They offer a lower return per premium dollar than straight life annuities.

A period certain annuity guarantees payments to a beneficiary for a specific number of years even if the annuitant dies before the end of the period, but it will continue payments to the annuitant for his or her lifetime. The use of a beneficiary guarantees that a specific sum will be paid out by the issuing company.
An annuity with a five-year period certain option and a payment schedule of $6,000 per quarter would guarantee payment of $120,000 regardless of whether the owner died before the five-year period was up. It is customary for insurance companies to pay the beneficiary in a lump sum in case of the annuitant's death rather than continuing to make installment payments. If the annuitant lives past the five-year period, the payout will continue in the normal manner until the annuitant's death.

Another form of life income option guarantees that in the event of the annuitant's death the company will pay out at least as much as was paid in premiums. This is called the refund option. If the annuitant lives past the point of the guaranteed refund, the amount of money called for in the contract will continue to be paid as long as the annuitant lives.

**Types of Refund Options**
A refund option may be either of two basic types.

Under a cash refund agreement, the company guarantees that in the event of the annuitant's death, a

refund in cash will be made to the beneficiary. The amount will equal the difference between the income that the annuitant received and the amount paid in premiums plus interest earned on that amount.

When the refund option is an installment agreement, the insurance company will make payments to the beneficiary until the total of what was paid to the annuitant and the beneficiary equals what the owner paid for the annuity contract plus interest. The size of payments to the beneficiary will depend on the period of time over which they are made--the longer the time, the smaller the individual payments.

Annuities with refund options pay lower amounts than comparable contracts without such options. They represent an extra cost for the issuing company. At the same time, they are attractive for consumers who do not like the idea of investing substantial sums in a product with the amount of return depending entirely on the length of the annuitant's life.

**Singular or Plural Annuitants**
The annuity contract may be written to provide for one annuitant only. The insurance company agrees to provide that person an income beginning on a specific date and continuing for a certain period, usually for the duration of the annuitant's life.

The annuity owner also may select a contract covering more than one person. A joint and survivor annuity is common, insuring two people such as husband and wife. Payments are made to the annuitants beginning on the date set in the contract and are guaranteed to continue as long as either annuitant survives.

Payments to the survivor may either continue in the same amount as when both annuitants were alive or be reduced. Under a joint and two-thirds survivor option, the survivor receives two-thirds of the original income, and under a joint and one-half income, half the original amount is paid to the survivor.

**Surrender Charges**
The termination of an annuity by the owner is called a surrender, and terms for such an action are included in the annuity contract. An individual who surrenders a contract turns in the documents stating the contract terms to the issuing company, which gives the owner an amount of money called for in the contract. This is known as the surrender value.

The surrender value of a policy is in proportion to the number of premiums paid, but it does not always equal the amount the annuity owner has paid. The issuing company imposes surrender charges. Most annuities call for a period of about seven years during which some penalty is charged for surrender of the policy. This requirement makes an annuity unsuitable for a short-term liquid investment such as a bank deposit provides. Loan privileges are available on some annuities, but the loans carry interest charges and may be subject to income taxes.

## Annuity Benefits

Many people today are choosing tax-deferred annuities as a major component of their overall financial plan. Where previously an individual may have used savings accounts or certificates of deposit as a retirement vehicle, annuities allow for the deferral of the taxes due on the interest earned until a future date. This postponement of the tax bite allows money to compound faster because interest will be earned on dollars that otherwise would have been paid to the IRS. When annuities are withdrawn in the form of monthly income, the taxes most likely will be less, as the retiree will be in a lower tax bracket.

**Benefits of Fixed Annuities**
Balanced against the lack of liquidity in an annuity investment is the additional security provided through the life income protection that is guaranteed the annuitant. The cost of this benefit is included in the premium paid for the annuity.

A person accustomed to thinking in terms of an individual investment in a savings account may not realize that the issuing company pools the funds it receives from annuities and prices them according to statistical projections based on mortality tables. The numbers in the table allow an insurance company to project what its future obligations to annuitants probably will be, and how many dollars will be released to it by annuitants who die.

This information is combined through mathematical calculations with statistics on what the company can expect to earn on the money it holds and predictions of operating costs. The result of these calculations is used to fix the premiums to be paid by individuals purchasing annuities.

In this way an insurance company can promise to pay an individual a guaranteed income for life even if that income exceeds the total amount of premiums paid plus interest. Numbers in mortality tables are used by actuaries to calculate risks, premiums, and reserves necessary for successful operation of companies issuing annuities. Average life expectancies are used in these calculations.

A current mortality table, structured to show that all annuitants will have died by age 115, indicates that out of 100,000 people born in the same year, only 87,149 will still be living at age 65. During the following year 1,348 probably will die, leaving 85,801 survivors. Using such projections based on averages for every year of life, actuaries can calculate statistically sound rates for practicable premium charges.

Unlike savings accounts or certificates of deposit, annuities are pooled funds based on the participation of many investors. When an investor begins receiving income from an annuity, the money is coming from a pool that provides an insurance benefit to annuitants living long enough to collect from it.

If the annuitant lives long enough to use up both principal and interest of his own investment, the entire payment will be made out of the insurance fund.

**Tax Advantages**

The major advantage making annuities popular under current tax laws is that of income tax deferment on earnings during the investment period. When payout starts, only a portion of each payment to the annuitant is taxable income. The remaining part is considered to be the return of money paid by the investor into the annuity.

A calculation specified by the U.S. Department of the Treasury determines what part of the annuitant's income will be considered taxable. The amount is based on a projection of how much the annuitant will receive from the annuity by living to life expectancy. This total income is called the expected return. When it is determined, the percentage of that amount which was invested in the annuity is calculated.

**Determining Cost**

To figure how much of an annuity is taxable one must determine the cost (investment in the contract). One of two methods can be used to determine cost:

1.) Simplified Method- This method relies on the annuitant's age at his or her annuity starting date. This date is either the first day of the first period for which one receives payment under the contract or the date on which the obligation under the contract becomes fixed, whichever comes later. With the Simplified Method, an IRS provided factor and formula is used to determine cost in the plan.

The Simplified Method must be used if the annuity starting date is after November 18, 1996, and if the person receives their pension or annuity payments from the following qualified plans:

a.) A qualified employee plan.
b.) A qualified employee annuity
c.) a tax-sheltered annuity (TSA) plan or contract

-Or-

At the time the annuity payments began, the recipient was at least 75 years old and was entitled to annuity payments from a qualified plan that are guaranteed for less than five years.

2.) The General Rule- This method is used to determine the tax treatment of pension and annuity income from:
    a.) A nonqualified plan such as a private annuity, a purchased commercial annuity, or a non-qualified employee plan.
    b.) A qualified plan if the following applies:
        i.) The annuity starting date if before November 19, 1996 (and after July 1, 1986) and the annuitant does not qualify to use, or chooses not to use, the Simplified Method.

ii.) The recipient is 75 or over and the annuity payments are guaranteed for at least five years.

-Or-

c.) An Individual Retirement Account (IRA)

The IRS provides life expectancy tables to assist the taxpayer in computing the minimum required distribution amount. In general one can recover the net cost of the annuity tax-free over the period that he or she is to receive the payments. The amount of each payment that is more than the part that represents the net cost is taxable. Under the General Rule, the part of each annuity payment that represents net cost is in the same proportion that the investment in the contract is to the annuitant's expected return.

Expected return is the total amount the eligible annuitants (remember, there can be more than one with joint and survivor annuities) can expect to receive under the contract. The IRS provides actuarial tables and formulas to determine the cost and income portion of annuities.

If the expected return is $300,000 and the annuitant paid $180,000 on the contract, that amount represents 60 per cent of the return. Once set, this percentage figure is used yearly to specify what part of the annuity payments should be considered return of capital and how much is subject to income taxes. In the example, 40 per cent of each payment would be taxable income.

A ten per cent income tax penalty is applied to lump sum withdrawals from annuities before age 59 1/2, unless the amount is one of a series of withdrawals of approximately equal size over a lifetime. An exemption also applies in case of death or disability. The ten per cent withdrawal penalty applies whether the amount is a loan or an actual withdrawal.

An exception to deferral benefits applies in the case of business-owned annuities. If a corporation, partnership, or trust owns an annuity on the life of an employee, interest earnings or annual gains in the contract are subject to current income taxes. An exemption from this rule applies in the case of annuities that are part of qualified plans such as pensions and similar employee benefit arrangements. Another exemption is for immediate annuities.

The exclusion of taxable earnings on annuities also applies to IRAs and 403(b) tax-sheltered annuities sponsored for employees by certain non-profit corporations.

In general, however, for an individual the tax-shelter advantage of an annuity is a major consideration and has brought about the sharp increase in popularity for these investments. They are especially well suited for college funds. An annuity purchased for a pre-teen and held at least ten years would carry at present rates a tax on withdrawals of around 25 per cent, which probably would compare favorably with the parent's tax bracket.

Of course there is always a possibility that tax rates might be raised by that time or that Congress might revoke the tax-deferral advantage for annuities, but no investment offering a similar return is without risk.

**Interest Earnings**

Many investors also are attracted to annuities because they provide competitive interest rates. These fluctuate but often rank above certificates of deposit, high- yield tax-free bond funds, and similar investments. Interest guarantees vary with issuing companies, some of which will pay an initial rate for one or two years and adjust annual guarantees after that. Others will offer interest rates pegged to Treasury bill or consumer price indexes.

A bailout provision in an annuity contract will allow the owner to cash in the policy without paying any surrender charge if the interest rate falls by a certain percentage from the original rate, even after the expiration of the initial guarantee period.

A contract, for example, might have offered an interest rate of eight per cent guaranteed for one year and called for a surrender charge on a premature withdrawal within seven years from the purchase date. It also promised a bailout provision of one and one-half per cent. After a year, the next guarantee was for payment of six and one-half per cent interest in the coming year.

The buyer of the contract would be exempt from surrender charges on cashing in the policy at any time because the interest rate had dropped more than the specified one and one-half per cent bailout provision.

An annuity, although not liquid in the sense that a bank account is liquid, does provide ways for individuals to surrender their contracts and withdraw their funds during the accumulation period. The bailout provision is one of these. Other penalties and surrender fees will be specified in the annuity contract, and the alert prospective buyer will compare the offerings of various companies in that regard.

**Risks Involved**

Annuities are not protected by the Federal Deposit Insurance Corporation and the buyer needs to be very careful in selecting an annuity provider. Fixed annuity contracts, however, are protected by state and federal regulations governing insurance company operations. Many states require other insurance companies to help meet the obligations of one that fails, but delays and paper work are involved in such cases.

A risk facing the fixed annuity investor like every other individual trying to provide for the future is that of inflation. An annuity providing an income of $1,000 a month might seem adequate now, but twenty years of high inflation could make it insignificant.

The guaranteed dollars do not fluctuate with price levels but stay the same. They are worth more in times of deflation, but less and less during continuous inflation such as that prevailing in recent years. This problem led to the development of the second major type of annuity investment, the variable annuity.

**Introduction of Variable Annuities**

Much interest and controversy greeted the introduction of the variable annuity by the College Retirement Equities Fund in 1952. The Teachers Annuity and Insurance Association designed the CREF when it became apparent that inflation was a problem that could not be expected to go away.

Some companies in the insurance business accepted the variable annuity idea while others opposed it. Legal questions were raised. The Supreme Court ruled in 1959 that variable annuities are not insurance and are subject to federal regulation as securities.

The variable annuity offers payments that fluctuate according to investment results rather than paying off in a fixed amount of dollars. Premium dollars for variable annuities are invested chiefly in fluctuating dollar investments like common stocks and other equity investments, while investments for conventional annuity funds are usually in bonds and mortgages.

Both fixed and variable annuities have as their aim the liquidation of principal over a period of time, often the lifetime of the annuitant. The difference is that one pays fixed dollar amounts and the other pays variable amounts.

Over the long inflationary period in the second half of the twentieth century, the general trend has been for stock prices and the cost of living to move in the same direction. For this reason the purchaser of a variable annuity looks forward to receiving a higher dollar income in times of higher prices so that stability in terms of purchasing power will be maintained by the investment. A fixed dollar annuity cannot provide this type of stability.

**Unit Values**

Most insurance companies have adopted a unit method to express variable annuity values. Two types of units are used corresponding to the two time classifications for annuities, the accumulation period and the distribution period. The premiums paid by the annuity owner are used to buy units of the annuity fund under this system.

The value of the units fluctuates in the case of an annuity being paid for on a deferred basis, with monthly, quarterly, semiannual or annual payments. For an annuity with quarterly payments, the premium for the first quarter of the year might buy six units for the second quarter five units, for the third quarter eight units, for the fourth quarter seven.

The purchasing power of the dollar does not run in a straight upward line. Changes in the cost of living and changes in common stock prices do not always move exactly together. Thus a well-managed flexible annuity fund requires maintaining a balance in the type of investments that will offer the greatest advantage.

**Company-Managed Annuities**
The first variable annuities introduced in the 1950s were managed by the companies issuing them. In this type of annuity, premiums paid in by owners are pooled and placed in a separate account from the company's other investments.

Like a mutual fund, the account is under the direction of investment managers who buy and sell a varied mix of stocks, bonds, government securities, and possibly other investments on a continuing basis to generate a competitive return for the annuity owners whose funds they are managing. Various economic indicators are used by the investment managers to make timely decisions with the aim of maximizing profits.

Companies selling variable annuities must meet state and federal regulations under the supervision of the Securities and Exchange Commission, Internal Revenue Service, and state regulatory agencies. An advantage to annuity investors is that the separate fund for their premiums is beyond the reach of the issuing company's creditors in case the company runs into financial difficulties.

An investment portfolio for annuity funds might consist at the beginning of a given year of a combination of stocks, bonds, and money market instruments with 37 per cent in stocks, 18 per cent in bonds, and 45 per cent in the money market. If a stock market slide began, the investment managers might sell all the stocks and go to a combination of 63 per cent in bonds and 37 per cent in money market instruments.

This sort of block trading on the part of many institutional investors has been blamed for making stock market drops worse. But when stocks start a comeback, investment managers are quick to take advantage of the upswing and return to a different portfolio mix. By the end of the year the fund might be more evenly divided, 39 per cent in stocks, 36 per cent in bonds, and 25 per cent in the money market.

**Self-Directed Annuities**
An annuity owner who wants to control the way his premiums are invested can choose a self directed variable annuity instead of depending on the insurance or other issuing company's investment managers. In this way a knowledgeable owner can vary investments as economic conditions or the investor's own objectives change.

The application form for a self-directed variable annuity will show what choices are available in the selection of investments. There may be a fixed account with interest guaranteed for a certain period, which may be a calendar quarter, a year, two years, or possibly longer. Under this option the safety of the principal is guaranteed.

Along with the fixed account choice the form may offer mutual funds with various objectives. An emerging growth fund would be composed mainly of common stocks of companies with the potential for long-term capital growth. A growth stock fund would have a long-term objective for growth of capital and future income rather than current income, and its investments would be in common stock of companies with good growth histories.

A cash management fund might be chosen with investments mainly in U.S. government securities. The objectives here are simultaneous preservation of capital, current income, and liquidity. A financial bond fund would be composed of high-grade bonds and have as objectives high-yield current income and preservation of capital.

Contract stipulations would set out conditions established by the issuing company for frequency of fund transfers, minimum amounts, withdrawals, and guarantees to beneficiaries, annuity payout terms, and initial and subsequent minimum payments.

The customer indicates on the annuity application, in percentage units, how each premium paid in is to be allocated between funds. The entire premium can be invested in a single fund, or the units can be divided among the different funds in whatever mix the applicant chooses.

**Investment Changes**
An individual's choice of investments, unless entirely on a random basis, will depend on three factors. They are economic conditions, the individual's financial status, and the objectives and philosophy behind the investment. These naturally change as time goes by. The appeal of a self-directed annuity is that it makes possible the annuity owner's opportunity to change the investment mix to suit changing conditions.

Most individuals grow more conservative as they grow older and may prefer to switch from a stock-dominated portfolio to one that emphasizes security, perhaps even to a fixed fund. On the other hand, an investor who has accumulated a large enough nest egg in order to feel secure may be inclined to put some units in more aggressive and riskier investments. It is also possible that losses in other investments may cause the investor to switch his annuity choice to a fixed fund.

The investor with a self-directed annuity, watching economic indicators, may switch from stocks to bonds when the stock market starts down and back to stocks again when the Dow begins to show signs of recovery. Keeping up with changing economic conditions is a time- consuming and risky business. For those who want to spend their energy and time in other ways the fixed annuity or the fixed fund in a variable annuity will be the preferred choice.

An individual in the 20 to 30 year old bracket with some money to invest might select speculative growth funds in the belief that there will be plenty of time available to switch to more conservative fund choices if necessary. A man in his middle years may begin to shift funds to a fixed option, leaving only 10 per cent or so in growth funds. Someone who has reached age 65 and is receiving annuity payments may divide his investment units' half-and-half between a fixed fund and the bond market.

**Types of Units**
Statements on the value of variable annuity accounts are provided regularly to investors, but computation of the exact worth of the investment at any given time is complex because of fluctuating market values. Most companies express annuity values in units rather than dollars.

During the accumulation period while premiums are being paid in, the term accumulation units refers to the current status of the account. When the annuity matures and payout start to the annuitant, accumulation units are converted into that which is referred to as annuity units.

The value of accumulation units changes as market values change. If the annuity is company-managed, the changing values correspond to the performance of the investment pool. Like a mutual fund share, each accumulation unit of a variable annuity has a designated value on any given day. In the case of a self-directed annuity, the value of each accumulation unit is determined when the values of the fund or funds the policy owner has chosen are totaled and divided by the number of units.

As time goes by, the number of accumulation units increases as additional purchases are made, although the value of each unit will vary through the life of the contract according to market levels. This is similar to the way mutual share values are calculated.

If an annuity investor paid $100 monthly premiums and the accumulation unit value was $5.00 on the day of his first payment, he would be able to purchase 20 units. By the time his next premium payment came due, the unit value might have risen to $5.05 and he would only be able to purchase 19.80 units with his $100. The next month if the unit value dropped to $4.87 the total of investment units purchased by the $100 payment would be 20.53.

Thus the investor would be adding a certain number of units to his portfolio each month, but the exact size of that number would depend on the current market price for each unit as long as the premium payments stayed the same.

The value of the units will continue to fluctuate throughout the accumulation period. When the annuity matures, the accumulation units will be converted into annuity units. The annuitant will be credited with a certain number of units which depends, in addition to the current market value, on four factors.

**Choice of Payments**
The first determining factor is the annuitant's age. The insurance company or other issuing agency

calculates from mortality tables what will be needed to provide a designated amount of lifetime income at a specified age.

The second factor is the number of guaranteed payments. If the annuity owner has chosen a period certain life income option, an extra charge for the guaranteed period will enter into the calculation of the annuity unit.

As the third factor, the issuing company projects what interest rates can be expected while the annuity is in force. If a high interest rate is predicted, the value of the annuity unit will be greater than if a lower rate is expected. Usually insurance rates are projected annually to determine projected investment returns.

As a final factor, administrative expenses of the company are calculated in determining the annuity unit value.

**Payment Options**

The number of annuity units credited to each payout will remain constant over the payment period. The annuitant may choose a fixed or a variable payment or a combination of both.

With a variable payment the value of the annuity may fluctuate as it did during the accumulation period. The performance of the investment portfolio and general administrative costs of the company will cause the variations. Thus the amount of annuity payments will fluctuate.

If an annuitant had, for example, 10,000 accumulation units at retirement time which the company converted to 100 annuity units, each worth $10, the first monthly payment would be $1,000. If the annuity unit value went up to $10.17, the next payment to the annuitant would be $1,017. But if the unit value then declined to $9.73, the annuitant would receive only $973 for the next monthly payment. If the unit value then rose to $10.57 the next check to the annuitant would be for $1,057.

Variable annuities continue to fluctuate after the retirement income period begins, first because the value of the portfolio changes constantly to reflect current market conditions, and second because the investments in the annuity contract also change just as they did during the accumulation period. The insurance company's investment managers buy and sell the stocks and bonds and whatever other interests there are in the portfolio in the case of a company-managed plan. The contract owner may change the contents of the portfolio in a self-directed plan.

**Theories of Performance**

When the variable annuity concept was first put on the market in 1952, the idea behind it was the designing of a financial instrument to combine the guarantees of annuities with the growth potential of equities for a hedge against inflation. A widely held theory at that time was that common stock prices and the cost of living tended to move in the same direction. Through the 1950s and 1960s this theory seemed to be valid, but in the next two decades there were wide fluctuations in the relationship between the consumer price index and Standard & Poor's index of 500 stocks.

Inflation still continued to accelerate even through periods of recession. This phenomenon was explained by some financial experts as due to the fact that when prices rise rapidly there is a corresponding increase in interest rates. A sharp rise in interest rates brings a downward stock market reaction.

It was pointed out by variable annuity proponents that the product was not intended as a temporary hedge against sudden inflation, but rather was based on the expectation of a long-term correlation between inflation and investment returns. In this view a variable annuity would give investors an increase in income as the economy increased in productivity.

Nevertheless, holders of CREF annuity instruments were considerably disturbed when their unit value dropped almost 40 per cent in three years beginning in 1973. Individuals who had started drawing their annuity payments saw the amount of money they were receiving go down while consumer prices zoomed upward. Those who were still in the accumulation period, paying premiums on their annuities, saw an even worse drop in unit prices of more than 50 per cent. A survey over a longer time period, however, showed that the CREF annuity unit value did indeed increase along with the cost of living. From 1967 to 1987, while the cost of living rose 245.7 per cent, the CREF unit value increased 385 per cent.

Measuring by other intervals within that 20-year period did not give such happy results. Between 1970 and 1983 the consumer price index increased each year for a total gain of 157 per cent. CREF annuity unit values increased during only seven of those years, gaining a total of about 47 per cent. It may be noted that there were two sharp recessions during that period. Other variable annuity companies had similar experiences during that time.

As the long-term advantages of variable annuities have become more apparent over the years, they have met with wide acceptance. Stock market values have increased and inflation remained in check throughout the 1990's. The value of securities behind the variable annuities has increased as well, making this seem like a smart investment choice for retirement.

**Risk Factors**

Variable annuities are not suitable for every investor. Even though the combination of flexibility and guarantees offered by the flexible annuity is an advantageous one, there are special concerns connected with its use, especially for a person accustomed only to fixed investments.

Neither a fixed nor a variable annuity is covered by federal insurance. Guarantees backing the contract are those made by the issuing company, and for that reason it is essential for the prospective investor to check very carefully into the record and reputation of the carrier before signing a contract.

In past cases of insurance company failure, other insurance carriers have taken over the financial obligations of the failed company, but this process can cause delays and does not always pay the interest originally promised.

Investors also need to realize that money they put in annuities can either grow or decrease in value. The investor's own financial position and tolerance for risk need to be given careful consideration in constructing a portfolio.

During the accumulation period of an annuity there is time to correct errors and adjust to market conditions, but when the retirement period comes an investor still may need to make adjustments and will tend to be conservative in choices. There is less time available then to recover from wrong decisions.

The choice between a company-managed and a self-directed annuity will depend on the investment experience of the customer and how much he may wish to be involved in portfolio decisions. A person with limited knowledge of the stock market probably would be better off with a company-managed annuity. The customer who chooses a self-directed annuity will need to keep up with changing economic conditions and periodically review his investments to see if they are appropriate both to the economic situation and to personal needs.

In addition to market risk, there are other uncertainties facing investors in variable annuities. There is legislative risk, for example. Congress has made tax laws favoring annuities as investments, but it also has the power to change tax laws in the future. Variability of interest rates is a risk affecting portfolio investments in bonds. Economic risks may involve recessions, depressions, or worldwide dysfunction of the economic system.

It is possible for an investor to choose a combination annuity in which a portion of the money put in is used for a fixed annuity and the rest for a variable annuity. This combination, or balanced, annuity plan makes it possible for the investor to have both the guarantees of a fixed annuity and the inflation hedge of the variable annuity.

**Fees and Charges**

Fund managers for the issuing company set a schedule of fees and other charges for each annuity contract, and the customer needs to be aware of these before concluding the purchase.

Both fixed and variable annuities carry a surrender charge limiting the amount of money that may be withdrawn during the early years of the contract. In some cases there is a declining charge, for example starting with six per cent of the total value of the policy during the first year and decreasing by one percentage point a year after that. In such a contract there would be no surrender charge for withdrawals

after the sixth year.

Management charges usually are imposed for investments in company-managed accounts. The contract charge might be $25 a year for administration in addition to an investment management fee of one per cent or more of the total value of the account. A guaranteed death benefit and coverage of administrative expenses involved in providing a life income usually are included with these charges.

**Tax Benefits**
The major factor in the current popularity of annuities probably is the tax advantage they offer. The same tax deferral as for an Individual Retirement Account is available, but the maximum investment in an IRA is $2,000 a year and in an annuity it is limited only by the investor's financial status.

A mutual fund investor has to pay income tax on yearly dividends and capital gains even if no payments are received by the shareholder during the year. But an investor in mutual funds through an annuity is not subject to income tax on the gains until money is actually paid out.

With a successful investment policy that takes advantage of market conditions, the annuity purchaser can build a retirement fund without interference from income taxes on the investment dividends during the accumulation period. Only when money is withdrawn do taxes come due. An investor who has a lifetime income from an annuity during retirement probably will be in a lower tax bracket at that time than during the accumulation period of the annuity contract.

**Funding Pension Plans**
Annuities can be used as funding mechanisms for retirement plans in business. A deferred compensation plan for a key executive who is due a raise but does not need the money at the time can put off receipt of the raise until retirement. Such an agreement can be funded through the purchase of an annuity.

Payments on the annuity are not tax deductible to the business, but when proceeds are paid to the employee on retirement they will be deductible as compensation. They will be taxable to the employee but presumably at a lower rate than would have applied during full employment.

This is a non-qualified plan under IRS guidelines. For a qualified plan covering a group of employees, the employer must put the plan in writing, communicate it to the employees, and file it for approval with the IRS. All eligible employees must be included in the plan without discrimination. Under an approved plan the employer's contributions to the plan are tax deductible.

A Keogh Plan or HR-10 for the self employed or for unincorporated businesses permits contributions for eligible employees of up to 25 per cent of compensation, not to exceed $30,000 annually. If eligibility and vesting requirements are met, an HR-10 can be a qualified retirement plan. Funds earned by HR-10 contributions are tax deferred until they are paid out at retirement.

If such funds are invested in annuities, the retirement benefits can be guaranteed for life. Known as a mortality guarantee, this feature is not available through savings accounts or other investments in which the HR-10 contributions may be placed. The Keogh Plan may be funded through individual annuities for each participant or through a group annuity contract covering all participants.

Under pension plans for corporations, the same contribution limits as for the HR-10 apply. Such a plan may be a defined contribution plan, which requires a fixed contribution from the employer, or a profit sharing plan, under which no plan contribution is required if the corporation has no profits.

The defined contribution plan specifies the amount to be contributed each year but not the amount of the benefit at retirement. Under a defined benefit plan, the amount of the benefit is specified but the amount of the contribution will vary depending on the amount of the benefit to be funded.

Although the corporation may choose to deposit funds contributed to the retirement plans in a bank account or use it for market or other investments, the only way of securing a guarantee of mortality, or payment for life, for those receiving the retirement funds is an annuity investment. Usually a group annuity is used to cover all participants.

A Tax Sheltered Annuity or Tax Deferred Annuity is a special type of arrangement for certain non-profit organizations approved by the IRS. Under this plan employers such as churches, hospitals, school systems, and other local government entities can allow employees to take salary reductions equal to the amount of money placed in the plan. These contributions are exempt from current taxation. Earnings on the contributions invested in the TSA are deferred until receipt. The limit on such contributions is 20 per cent of earnings with a ceiling of $9,500 a year.

**Personal Uses**

An annuity purchased for a child to provide funds for college would accumulate interest tax-free until time for withdrawal. If the annuity was placed in the child's name, the taxable portion then would be subject to tax at his or her rate, but there would be a 10 per cent penalty for early withdrawal. If the annuitant was a parent or grandparent who would be past the 59½-year age limit at the time of withdrawal, there would be no penalty, but the proceeds probably would be taxed at a higher rate. Personal situations need to be considered in making annuity arrangements.

A large lump sum insurance settlement, either from a life insurance policy or a liability claim, could be used to purchase an annuity for the beneficiary. Depending on the individual's situation, tax-free accumulation of interest until time for retirement, followed by lifetime benefits, could be the most practical lump sum investment.

A single premium immediate annuity might also fund a charitable donation. The annuity could be divided into two parts, half to provide the donor with an income and half to serve as donations to a charity. In such a case the charity would have the use of the money during the donor's lifetime and the portion of the funds going to the charity would be tax deductible.

**Cost Base and Tax Base**

Under IRS rules, amounts received as an annuity are those payable at regular intervals over a period of more than a year from the date payments began. Part of these payments is considered as the cost base, returning the investment in the annuity, and thus are not taxable. The money used to make the investment has already been taxed. The remainder of the benefit is the tax deferred amount which has been earned during the accumulation period, and it is taxable. This is the tax base portion.

For annuities with a starting date before Jan. 1, 1987, when new tax laws went into effect, an exclusion ratio was used to determine the amount of the tax base. It was the percentage given when the cost base was divided by the total expected return, a figure determined by the life expectancy of the annuitant from standard mortality tables. If the ratio came out at 25 per cent, that amount of each lifetime benefit payment was taxable.

On newer annuities, this ratio is used only until the full cost base is recovered, and after that the total amount of the benefit payment is taxable.

**RECAP**

An annuity is a contract under which the buyer agrees to pay a certain amount of money to the issuing company in exchange for a regular income over a specified period of time. This arrangement makes possible the distribution of income at the time it is needed through scientific liquidation of investment capital.

Originally the word "annuity" signified an annual payment, but a varied schedule of annuity payments is now available. An annuity is the reverse of life insurance, providing for payments during a lifetime instead of benefits at the time of death.

Annuities were traditionally issued by insurance companies because they had the mortality tables and statistical knowledge necessary for establishing the necessary investment pools. Thus insurance terms are used in issuing annuities. Payments during the accumulation period of the annuity are known as premiums.

Other types of investment advisors in addition to insurance companies have been offering annuities since income tax deferral provisions made this type of investment increasingly popular. Taxes on income from annuity investments are not due until benefits start, by which time the annuitant probably will be in a lower tax bracket than when premiums were being paid. Annuity investments are not guaranteed by federal

insurance as bank deposits are. Their safety depends mainly on the financial stability of the issuing institution, although state regulations do provide protection for fixed annuities offered by insurance companies.

Premiums paid in for annuities are placed in a pool for investment. Rates are set to make it statistically possible for the issuing institution to make payments for a lifetime in the case of a traditional fixed, straight life or pure annuity. Payments to the annuitant in this case stop at death no matter how short or long the payout period may be. Annuity tables and other adjustments make it possible for short life spans and long life spans of investors to balance out, leaving a profit for the issuer through returns from the investment pool.

Other more sophisticated types of annuities have developed to take account of the more or less continuous period of inflation during the last half of the twentieth century. Fixed annuity dollars did not offer expected security when their value was sapped by inflation. The variable annuity was developed to give flexibility in relation to the market place.

Premium payments are converted into accumulation units while the investor is paying on the annuity. When the contract date calls for payout to start, accumulation units are converted into annuity units. The unit values fluctuate in relation to treasury bill interest rates, the consumer price index, or some combination of agreed schedules. The variable annuity offers protection against inflation but is subject to market risks.

In addition to the two main types, fixed annuities and variable annuities, there are many different options available for premium and benefit schedules. A period certain annuity with a beneficiary named in addition to the annuitant will guarantee a payout of a specified sum. If the annuitant dies before that sum has been paid, the beneficiary will receive the rest. A joint and survivor annuity might pay a specified income to the annuitant until death and a proportion of that amount to a surviving spouse until death. Such provisions require higher premiums than straight line annuities.

An annuity provides an alternative to life insurance for someone who has no dependents and expects to have none, or for an individual who cannot meet the physical requirements for an insurance policy.

# CHAPTER SIX Fire, Property and Casualty Insurance

The oldest form of insurance known is marine insurance. Coverage for goods being shipped to faraway places began when Babylon was the financial capital of the world, around 2000 B.C. Merchants and traders had to borrow funds to finance their trade or to get goods on consignment.

Under a contract system devised by the Babylonians, the lender agreed to cancel the loan if the merchant was robbed of his goods. Such contracts carried a surcharge for protection over the usual rate of interest. They developed into a system of respondentia loans. The loans were made on the security of a venture and were repayable with interest if the voyage was successfully completed. The loan was canceled if the voyage failed. If a lender negotiated enough loans, he had a more or less regular ratio of loss. The interest charged in the respondentia loan actually amounted to an insurance premium to cover losses.

The practice of providing insurance simply on a premium basis is believed to have its origin in the Italian maritime city-states of the Middle Ages.

**English Developments**
Mediterranean traders brought the idea of insurance to London, where a coffeehouse owned by a man named Edward Lloyd became headquarters for many traders in maritime risks. In 1769 an organization of underwriters was formed at Lloyd's.

Lloyd's continues to do worldwide business today in much the same manner as in the 18th century. The old Lloyd's contract provides the basis of all marine insurance policies. The main features of the American system are the same as those of the old contract, although it is not rigidly followed in form.

**Insurance Principles**
As marine insurance developed, questions regarding disagreements were settled in the merchants' courts. The courts were established by the merchants to determine disputes in accordance with established mercantile custom.

The general principles of insurance law were recognized through dealing with marine risks in a time when long distance communication was slow at best. This posed a problem for early insurers. The insurer could inspect vessels before they sailed, but then had to rely on information from the insured concerning vessels in foreign ports, embarking on return voyages. Accordingly, under the law, the insurance contract became an instrument of the utmost good faith. Under this requirement the doctrines of concealment, representation, and warranty were developed.

**Inland Marine**
Marine insurers recognized the need for protection of goods and property being moved in other ways than by sea. Early in the 19th century this new class of transportation insurance was named "inland marine" to distinguish it from "ocean marine."

Besides covering moving or movable property and the facilities for its transportation, such as warehouses and docks, inland marine came to deal in "all risk" coverage. Industrialization and the growth of cities increased the need for protection against industrial and transportation accidents, theft, and third-party liability. This became known as casualty insurance.

**Insurance In America**
Two English corporations were granted a monopoly in 1720 in the American colonies. This prevented the organization of corporate insurers in the colonies. Individuals could issue insurance, but they could hardly compete with such organizations as Lloyd's of London. Mutual fire insurance groups were formed in the colonies. Some were a combination of volunteer fire companies and insurers. Benjamin Franklin was an organizer of one of the first of these, which is still in existence.

After the American Revolution the first capital stock insurance corporation was chartered in 1794 by the Pennsylvania Assembly. Early insurers in this country were chartered and regulated by the colonies, and after the Revolution by the states.

The Supreme Court in 1868 held in the Paul v. Virginia decision that insurance was not commerce and thus not subject to federal law. This decision was reversed in 1944 in the case of the United States v. South-Eastern Underwriters Association. The court held that insurance was commerce and when conducted across state lines was subject to federal jurisdiction.

Congress in 1945 passed the McCarran-Ferguson Act that allowed the states to retain control and regulation of insurance as long as they did not violate federal laws. The Act made state regulation the primary force in controlling the insurance industry. Regulation is overseen at the federal level by the Federal Trade Commission and the Securities and Exchange Commission, as well as Congress.

**Monoline Insurance**

Small insurers in the early days of American development usually specialized in only one class of insurance. This tradition was followed by state regulations. What came to be known as the "American System" of monoline insurance developed. Monoline contrasted the English system that allowed insurers to write all lines of coverage.

The Insurance Company of North America, in 1944, began an industry movement. As a result all of the states adopted regulations that allowed non-life insurers to write all kinds of insurance except life insurance and annuities. The regulations allowed life insurers to write health insurance and annuities as well as life insurance. This change made it possible to develop such packages as homeowners and family automobile policies.

**Fire Insurance**

As cities grew throughout the world, large buildings were constructed close to each other. As the trend continued the demand for fire insurance developed. Fire insurance has been referred to as "the most important contract in the world." The great London fire of 1666 resulted in such interest in fire insurance that the first fire insurance office was established in London the next year, in 1667.

Early fire insurance companies prepared their own forms. These included many fine print clauses that made restrictions hard to read. To prevent excessive losses to insurers in a single fire, several policies were issued on the same property. With separate policies differing in restrictions, it was hard for the insured to recover the full loss. Sometimes the insurers themselves were victimized.

In the United States during the 19th century efforts were made to standardize policies. Prominent New Yorkers who had been victimized by the fine print and conflicting policies lobbied for the standardization of forms. Finally the New York Board of Fire Underwriters prepared a standard policy and standard modifying endorsements. The policy form and endorsements became effective in 1887 in what was known as the New York form.

After the San Francisco earthquake of 1906 a more liberal form was adopted in California. Various states used versions of the two forms until a final combined standard form was adopted in most states in the 1940s.

Present fire insurance policies cover financial loss equal to the value of the property destroyed. The property value may be adjusted through an allowance for depreciation in some cases. In insurance contracts where there are several limits or boundaries, the smallest or most narrow is effective. Specific condition endorsements override such limiting boundaries.

When a company closes due to a catastrophic event several areas of the business loss must be considered. For example if a manufacturing business closes the closing will involve the loss of net profits and payment, continuation of expenses will be incurred to keep the staff together, meet indebtedness obligations, and assure the possibility of resumption of business.

Insurance protection to cover such catastrophic events is called "business interruption loss coverage." It formerly was known as a "use-and-occupancy loss coverage", and is still sometimes termed "U and O." The form for this type of coverage specifies the insurer's liability for total or partial suspension of the insured's business.

A private individual may be protected against additional living expenses caused by a home fire. Coverage of expenses for rent while the homeowner's property is being repaired or rebuilt is known as rental-value insurance. A landlord whose premises are lost to fire and whose income from rents is cut off may obtain rental insurance under a form similar to a use and occupancy business policy.

A commercial firm may get coverage for the loss of profits on finished merchandise in a profits insurance policy. As for commissions on the sale of goods destroyed by fire, there is some question as to whether such a contract is justified as an indemnity, because the values insured are not in existence and may never come into existence. Profits have always been insurable under marine insurance. Some insurance companies will issue established retailers policies covering the loss of goods at the retail selling price.

All-risk policies under the expanded development of inland marine insurance now provide competition for traditional fire insurance policies and their endorsements. For that reason many fire insurance companies now offer supplementary coverage for buildings and contents that insure against such risks as windstorm, hail, explosion, and other forms of damage.

**Property and Casualty Insurance**

Property and casualty insurance is best considered as two components; personal and commercial risks. The most common type of personal risk covered is that protected under homeowners insurance. This is a package policy, one that combines two or more separate coverages into one policy. Prior to the introduction of homeowners insurance in the 1950's, property insurance on a private dwelling and personal property, theft coverage and personal liability insurance could not be obtained in one policy. With the enactment of multiple-line laws, insurers were allowed to combine these coverages into one policy.

Business entities have title to valuable commercial buildings and business personal property such as machinery and computers. Such property can be damaged or destroyed by a direct physical loss. As a result of the direct physical loss, businesses can incur indirect losses, such as extra expenses or the loss of business income. Business operators can reduce their exposure to risk with a monoline policy or a commercial package policy, combining two or more coverage parts into a single policy.

Because of the nature of business today, property and liability insurance can be combined into a single policy known as a multiple-line policy. This commercial package policy is widely used. It can be tailored to cover commercial property and liability loss exposures in a single policy, with the notable exceptions of workman's compensation and surety bonds.

**Development of Fire Insurance**

Fire insurance carriers when expanding into the casualty field issued policies that covered, by substitution of terms, such hazards as riot and civil commotion, windstorm and tornado, earthquake, hail, water damage, and rain. Other casualty companies specialized in burglary and robbery insurance, plate glass insurance, boiler and machinery insurance, and credit insurance. Sometimes one casualty company would carry all of these, but many carriers would write only one or two lines. Livestock insurance and title insurance are usually handled as exclusive lines.

A basic property coverage form lists the parties to the contract, consideration, risk transferred including property covered, term, hazards, loss procedure provisions, and limitations and qualifying clauses. With the consolidation of coverage made possible by the lifting of monoline restrictions, many hazards in addition to fire are now covered in a standard homeowner's policy.

Flood insurance is a separate hazard from damage caused by rain or broken pipes. Many people do not realize that in a standard homeowner's policy, flood coverage is excluded. Damage caused by flooding, flood-related erosion, flood-caused mud-slides, or other flood-related losses will only be covered under flood insurance.

This coverage is required for homes with federally funded mortgages if they are located in Special Flood Hazard Areas (SFHA) designated by the Federal Emergency Management Agency. These areas have a one per cent chance of flooding in any given year. It is estimated that more than 85 per cent of home owners with property in SFHA have not carried the required flood insurance. The property owner is now

subject to having their lender purchase the coverage after notification and non- compliance by the owner.

The millions of households in regulated flood-prone areas are estimated to stand a 26 per cent chance of being flooded during the life of a typical mortgage as against only a one per cent chance of burning during that time.

**Auto Insurance**
The form of casualty insurance which affects the largest number of people in the United States is automobile insurance. Because the auto moves about, special policies had to be devised for it as distinct from those on fixed property.

The first liability insurance was written in England on an electric cab in 1895, and the first collision insurance in 1899. The original basic coverage for property loss on automobiles protected against destruction by fire, theft, injury through collision, and other damage to the car by breakage of glass or while being transported.

The risk of being called on to respond for damages done to others through the use, ownership, or maintenance of the car came under liability coverage. Laws requiring auto liability insurance are in effect in most jurisdictions. In many states there is a requirement that drivers must show proof of financial responsibility before receiving license plates or a driver's license. Creditors require collision and comprehensive coverage for damage or theft to vehicles for which they hold liens.

**Aviation Risks**
Many new risks arose with the development of aviation in the 20th century. Forms and practices had to be established to deal with them, but the basic form of inland marine insurance was retained. Many details are involved in this specialized type of insurance. A clear definition of the risks involved is always necessary.

Among the risks to property are those of destruction or damage to the plane or its contents. There is risk of damage to property on the ground caused by falling planes or their contents. Aviation coverage may be carried by the owner of the plane. It is also available to the owner whose property on the ground that is in potential danger.

Fire insurance for planes is written in two forms. One covers fires in the air. The other covers fires under all circumstances. Crash insurance is written with large deductibles. In some parts of the country a special form is written covering tornado damage to airplanes. New forms of coverage are developed as the size and construction costs of airplanes increase.

**Boiler and Machinery Insurance**
Manufacturers carry a type of policy known as boiler and machinery insurance. This originally covered only the explosion of steam boilers but eventually was combined with other policies to apply to any type of machinery breakdown. This insurance covers loss from accidents to designated objects described in the policy schedule. It protects the owner against destruction of his own property and provides the owner with liability coverage for the property of others. It also can cover death or injury of persons involved in such accidents. The policies set limits per accident but usually do not set a total limit of liability, since multiple accidents within the policy period are a remote contingency.

**Burglary, Robbery, Theft Insurance**
Loss of property through piracy and theft by crew members has always been covered under marine insurance. Only in fairly recent times has it been possible to secure protection against loss of property by theft from its normal location. A royal charter was sought in England in 1787 for a company to offer such insurance, but that and other sporadic attempts during the next hundred years did not amount to much. Even as late as 1900 this branch of insurance was regarded by companies and their representatives as a sideline. During the 20th century it became a multi-million dollar business, even excluding car theft coverage which is classified as a marine insurance risk.

Theft is a generic, not a legal term. Stealing under the law is known as larceny, and specific terms are used in policies to indicate the coverage involved. Burglary is defined in standard original policy forms as loss of contents "occasioned by any person or persons who shall have made felonious entry into the premises by actual force and violence . . . of which . . . there shall be visible marks made upon the premises at the place of such entry." Robbery means "a felonious and forcible taking of property by violence inflicted upon a

custodian or by putting him in fear of violence."

The terms "theft" and "larceny" are synonymous and are used in connection with residence and office policies designed to cover every form of stealing, such as that by employees. "World-wide" policies cover felonious loss of specifically named articles of jewelry or furs anywhere in the world.

**Other Property Insurance**
Various hazards to property owners now come under combined coverage such as that in homeowner's policies. They may, however, be obtained in separate policies or endorsements.

Damage from water leakage became an important commercial consideration with the development of automatic sprinkler systems guarding against fire loss. Exceptions to water damage liability include leakage caused by fire, lightning, earthquake, explosion, invasion of foreign enemies, civil commotions, riots, any military or usurped power, order of a civil authority, or any fraudulent acts of the insured. Damage to the system itself is also excluded.

A similar policy will cover accidental leakage from plumbing on the premises besides the sprinkler system. As explained earlier, standard water damage insurance does not include flood loss coverage.

Loss or damage due to strikes, riots, and similar violence is covered under riot and civil commotion insurance. It also covers explosions due to such causes as well as other explosions not covered under boiler and machinery policies. Riot and civil commotion policies are written on certain property for a fixed time and up to a fixed maximum limit.

Separate policies may be obtained covering windstorm damage, although this usually is included in fire insurance. Loss to specified property by "windstorms, cyclones, and tornadoes" is covered under windstorm insurance. A precise definition is given in the policy can exclude hail, snow, or other weather disturbances which often accompany high winds.

The form for earthquake insurance is adapted from fire policies by substituting the word "earthquake" for "fire" wherever it occurs, and eliminating provisions that obviously apply only to fires. Earthquake damage is usually partial, and provisions are made for coinsurance as well as for deductibles to eliminate trivial claims. No attempt is made to define "earthquake" in the policy. There is a provision that if more than one earthquake shock occurs within 72 hours during the term of the policy it is to be considered a single quake. Earthquake insurance is written almost entirely on the Pacific coast.

**Rain Insurance**
Rain in itself seldom causes direct property loss. Policies known as rain insurance are usually written as protection against cancellation of outdoor events and the resulting expense of having to issue "rain checks" and re-schedule arrangements. Even a department store sale that has been extensively advertising may come under rain insurance. Rain insurance is more frequently purchased for such things as sports events, fairs, and public exhibitions.

The loss under the policy becomes payable if a stated amount of rain falls between specified hours on a given day. Expenses incurred, loss of expected income, or both may be covered under the policy. Premiums are payable in cash and an application must be made at least a week before the event.

Hail insurance is written mainly on agricultural crops. The policy begins 24 hours after receipt of the application by the company. If the company declines the risk, it must immediately notify the applicant and the insurance ceases on delivery of the notice. The policy does not have a fixed term but has an expiration limit, usually at the end of the expected hail or crop season. Settlement of partial losses is provided on a 100 per cent coinsurance basis.

Frost insurance for growers of citrus and other deciduous fruits is not widely written. There has been a considerable demand for it and some efforts have been made to cover hail, frost, and other crop losses under government-backed insurance. One difficulty is determining the amount of actual loss. Crop values fluctuate and in times of falling prices such policies may become price rather than crop damage insurance. Determining what proportion of the crop has been damaged is a difficult. Government subsidized crop insurance has been tried in some areas.

**Livestock Insurance**
Many small associations and some commercial carriers offer livestock insurance. It has been carried on from ancient times by mutual benefit organizations. Conditions are hard to control, values are variable, and the major impediment is the moral hazard involving care given the covered livestock.

One policy states that "the company shall not be liable beyond the actual cash value of any animal at the time any loss occurs in the condition in which said animal then may be." Although important to producers of valuable breeding stock, such insurance is not generally considered commercially significant except for full floater, full mortality policies covering animals anywhere in the United States or Canada and including the risk of transportation. Such coverage is used for racehorses, show animals, and similar stock.

**Surety and Fidelity Bonds**

There are warnings in Proverbs against becoming a surety for a stranger (Prov.6:1-5 & 11:15). Suretyship is obviously an ancient practice. In modern civilization, when one person enters an agreement and a second person guarantees the actions of the first person, the second person is called a surety for the first.

Suretyship with financial guarantees was on a personal basis until the 1800s. Surety was provided because of friendship or for other personal considerations. Heavy losses could result. The first company offering corporate suretyship in the United States began to do so in 1878.

Under professional suretyship, banks and others companies that employ a number of people have bonds written that cover whoever may hold a particular position, rather than a named individual. Such a bond is effectively an insurance contract, although it is a service fee for investigation of individuals or for the lending of credit.

A fiduciary bond guarantees the performance of an individual charged with a special trust, such as the guardianship of a minor. Most public officials are required to be bonded. Contractors, licensees, and many other individuals involved in contractual relationships are guaranteed by surety bonds. The fidelity bond provides indemnity only for dishonest actions on the part of the covered person.

Surety bonds also assume the risk of incapacity, whether technical or financial. Fidelity bonds are usually given as security for an implied obligation, while surety bonds cover an expressed obligation put in writing. The modern tendency is towards the issuance of a "blanket bond" to financial institutions. This essentially combines fidelity with burglary, robbery, and theft insurance.

A specialized form of coverage is found in a commercial blanket bond. One form provides protection from losses due to "larceny, theft, embezzlement, forgery, misappropriation, wrongful abstraction, willful misapplication, or any other fraudulent or dishonest act or acts" of any employee of the insured. Such a policy is not as broad as a banker's blanket bond. It does not cover loss due to robbery or other acts of strangers, or simple mistakes or misplacement of documents. Such coverage is available under combination contracts. Blanket position bonds are also available covering the occupants of named positions instead of the entire staff.

**Credit Insurance**
An important cause of loss to business proprietors, especially manufacturers and wholesale merchants, is failure of debtors. Credit insurance provides protection against such losses in excess of normal. Since the definition of "normal" controls the amount that can be called "excess," such policies require clear definition of the insured's credit practices and collection methods. The insurance carrier in order to be able to minimize loss must be given the opportunity to collect accounts which are likely to result in claims. Thus the writing of credit insurance is a complicated specialty.

**Title Insurance**
Title insurance developed from the fact that an abstract or report of title prepared by a lawyer or other professional title searcher contains no guarantee that the title is without defect. Negligence on the part of the searcher might result in a damage suit, but recovery would depend on the financial responsibility of the searcher. The title insurance policy covers the insured up to the limit named in the policy. It protects against loss due to defects in the title to real estate, subject to whatever exceptions are named in the policy.

The coverage is not for future events that might occur. It protects against loss that might be sustained in the future because of defects existing but undiscovered at the time the policy is issued.

**Liability**

If a house burns down or a piece of manufacturing equipment is destroyed through accident, it is easy to understand the peril being insured. The peril, even if it cannot be defined precisely, is easy to imagine and easy to insure. Legal liability is a different breed of peril. It arises out of the general rule of law that an individual is responsible for any loss or injury that he or she may cause another to suffer. The law creates three categories for describing situations in which one individual injures another; torts, breaches of contract and criminal wrongs.

The most common type of legal liability arises from an insured's torts. There are several types. When a person breaches his or her duty to respect the rights of another, that person commits a tort resulting in injury or damage to the owner of the right. Such harms include:

- Harming or injuring a person
- Harming an individual's property
- Harm to relationships, including abduction, injurious falsehood, and interference with contractual relations

A tort may be viewed in one of three ways by the law-

1.) Intentional interference- That is, a deliberate act.
2.) Strict liability- Statutory law dictates in particular situations that one party always shall be responsible for losses that occur.
3.) Negligence- This is doing something that a reasonable person would not do or not doing something that a reasonable person would do that results directly in the injury to another.

Legal actions to preserve and protect individual and property rights have grown more and more frequent. The risk of being accused of negligence has increased in modern society. It now affects almost every action, as well as non-action, in individual and corporate life. Liability insurance provides coverage designed to protect from financial hardship due to negligence.

Negligence is a tort, a civil wrong not based on contract. Most liability cases are based on common law, although some are covered by statutes.

Potential loss from liability is often considered a more important risk for coverage than property insurance. A homeowner might feel secure in having full coverage for the value of a $100,000 home, but the liability risk he could face for a serious injury on his property might result in a loss greater than the home value.

Liability insurance is third-party coverage. It arises out of loss or damage to persons other than the insured. Such policies generally provide two maximum limits. One covers the claim of one person and another covers the total claims in a single accident. There are many types of policies covering different classes of operations. Most familiar to the general public are automobile and employer's insurance.

There are also general and miscellaneous liability policies. A professional person needs protection against lawsuits charging error or malpractice. Medical cases are most frequent in this area. Insurance professionals, attorneys, accountants, engineers, and consultants now may require liability coverage.

For businesses a comprehensive general liability policy is popular. It covers on-premises and off- premises events. Products liability is growing in significance as million-dollar awards become common for injuries caused by defects in automobiles, appliances, foods, drugs, or other products.

An excess liability contract is gaining in popularity for both individuals and businesses. It is an umbrella policy that can provide coverage for claims that are above existing liability coverage.

**Terrorism Insurance**

The tragic events of September 11, 2001 brought to light the huge potential exposures insurance companies could face in the event of another terrorist attack. Faced with continued uncertainties about

the frequency and magnitude of future attacks, at the same time government and military leaders are warning of new attacks to come, both insurers and reinsurers have determined that terrorism is not an insurable risk at this time. As a result, in the closing months of that year insurers began announcing that they could not afford to continue providing coverage for potential terrorism losses. The effects of this trend have yet to be fully realized, but there is some indication that it has begun to cause difficulties for some firms in certain economic sectors. Considerable debate has taken place on what the federal government can do to keep commercial insurance companies involved in providing terrorism insurance, even without the protection that they normally receive from reinsurance.

In summary, because insurance companies believe that neither the frequency nor the magnitude of future terrorist losses can be estimated, they are withdrawing themselves from the market. Insurance for losses from terrorism is disappearing, particularly for large businesses and those perceived to be at some risk. This withdrawal is happening fastest among reinsurers. Direct commercial P/C insurers 'withdrawal has been slower and less complete because of regulatory constraints and legal requirements in some states that preclude insurers from excluding terrorism from coverage for workers ' compensation and for fire (irrespective of its cause). Because the insurers ' withdrawal has been gradual, the extent of the potential economic consequences is still unclear. What is clear is that in the absence of terrorism insurance, another terrorist attack would dramatically increase direct losses to businesses, employees, lenders, and other noninsurance entities beyond those resulting from September 11th. Furthermore, should the government decide to intervene after a future attack, it would do so without readily available claims-processing and payment mechanisms that exist in the insurance industry.

The attacks on the World Trade Center cost the insurance industry anywhere from $40 billion to $75 billion in claims, with property insurers picking up the bulk of the tab. The industry was able to cover its losses for this event, but in a letter sent to President Bush after the attacks, industry representatives warned that the cost of property insurance would quickly become unaffordable for most people. As a result, new construction would halt and financiers would be forced to suspend lending to developers—unless Congress and the president offered some kind of assistance to help keep costs down. The original House bill, passed early in 2002, would require insurers to pay for the first $1 billion of a future terrorist attack. The federal government would offer long-term loans to help pay for the rest. The insurance industry was not very enthusiastic about any plan that doesn't offer them direct aid. Instead, the industry preferred the Senate bill, sponsored by Sen. Christopher Dodd (D-Conn.), which would have insurers pay for the first $10 billion of an attack out-of-pocket. After that, the government would pay for 90 percent of any remaining claims. The bill hammered out by the conference committee in mid-2002 closely resembled the Senate proposal. It offered the insurance industry $100 billion in aid over three years. The federal government would pay 90 percent of any costs over $10 billion the first year, over $12.5 billion the second year and over $15 billion the third year.

**Workers Compensation**

Special problems with the responsibility for work-connected injuries and disease developed with the rise of the industrial society. Common law covering the master-servant relationship made it difficult for an employee to collect damages for a work-related injury. The employee had to prove negligence on the part of the employer.

A system of workers compensation laws beginning in the early 20th century provided relief for employees. They established the principle that the employer is liable, regardless of fault, for injuries to employees in the work place. The basic idea the laws are based on is that of economic loss.

Economic loss to employees due to accidents occurring at work is part of the cost of producing goods. The worker's economic loss is applicable to the work that was being done. As such it should be borne by consumers of those goods. To accomplish this, the cost is first assessed on the employer who produces and controls the marketing of the goods.

Workers compensation is now a recognized type of social insurance. It covers about two thirds of private employees and almost all public employees in the United States. Legal exceptions to the coverage include agricultural, domestic, and casual labor. Also, employees of firms having less than a specified number of workers may not be covered.

Employers are required by law to provide coverage through insurance. State agencies administer the law, and the applicable provisions of the state statute are included in workers compensation policies. The law takes precedence over any other policy provision.

Scheduled benefits may vary considerably from state to state. In general coverage includes medical expenses, loss of income, rehabilitation expenses, disability, and death. Insurance rates are based on the actual loss experience of the individual employer.

**RECAP**

Marine insurance developed in ancient times as money lenders charged extra premiums to cover loss of merchants' cargoes on which they had loaned money. Underwriters meeting at port gathering places such as Lloyd's of London established the general principle that an insurance contract must be one of the utmost good faith in order to be dependable in a time when communication during long voyages was impossible.

Inland marine coverage was an extension of marine insurance. It protected against loss to goods and property being moved in other ways than by sea, and came to deal with "all risk" coverage which developed into casualty insurance.

Monoline firms offering only one kind of insurance were common in this country until an industry movement divided coverage between firms writing life, health, and annuity policies on the one hand and companies writing all types of casualty insurance on the other. This made possible combined coverage such as that now available under homeowners' insurance and blanket liability coverage. Automobile insurance is the casualty line affecting the largest segment of the public.

States have the primary responsibility for regulating insurance companies under the McCarran-Ferguson Act of 1945. Terrorism insurance is a difficult field because losses can be neither predicted nor estimated. Workers compensation coverage required by law is administered by state agencies.

# CHAPTER SEVEN Government and Insurance

Social insurance has been defined as the attempt of government to apply the principles of insurance to the prevention of poverty. It modifies the traditional attitude that every man is master of his own fate, and incorporates the belief that society as a whole has an obligation for at least the minimum welfare of its members.

Mutual benefit societies and work-related organizations such as the guilds helped provide economic security for certain segments of the population for centuries in Europe. These groups were also established in colonial America.

With the Industrial Revolution and the growth of cities, people left the farms and became dependent on wages in exchange for their labor. Unemployment as well as sickness or injury could mean total financial disaster for the new city dwellers. Families could starve. Social unrest due to economic conditions began to be a serious threat to established governments.

The first modern system of social insurance went into effect in Germany in the 1880s. In addition to citizen assistance, it provided a more efficient and stable labor supply, as predicted by Chancellor Bismarck of Germany, thus contributing to the stability of government and industry. Britain began its social security program in 1897. France and other European nations followed suit.

Economic insecurity, distressed conditions, low wages and unsanitary living conditions helped lead to the appearance of the socialist philosophy. Do not confuse the concept of social insurance and the doctrine of socialism. Socialism is a doctrine that seeks to place in the hands of the people, directly or through their government, the ownership and control of the principal means of production and distribution.

The old Soviet Union said that their brand of socialism was a step on the road to Communism. Lenin taught that eventually the state and then the dictatorship would wither away once Capitalism was stamped out. Democratic socialists in the West always described the Communist system as neither socialistic nor democratic. It was state capitalism. Neither the state nor the dictatorship showed any signs of withering away; rather it was killed off by economic stagnation.

Many scholars think that the concept of social insurance was a response to socialism. Chancellor Bismarck was the first to initiate laws concerning social insurance in the 1880's. The general ideal of social security includes the right to a job, to fair pay, to sufficient food and clothing, adequate shelter and medical care, and protection against poverty in old age.

As high-minded as these goals may sound, people today have begun to question whether the government should be in the business of supplying limited entitlements for which there is an unlimited demand. Do such programs create a social safety net? Do they create a new aristocracy made up of the poor, the infirmed, the disabled, and the senior citizenry riding on the backs of a heavily-taxed working and middle class?

In the United States the first social insurance was workers compensation. It was enacted for federal employees in 1908 and made effective in various states beginning in 1911. This country, however, was still largely rural in the early 20th century. The idea that there was an unlimited supply of land and opportunity in the West was slow to lose its popularity. Jurisdictional controversies between the states and the federal government also made the development of social insurance slow in this country.

**Not a Public Assistance Program**

Public assistance, or welfare, is one type of solution to social and economic problems. It is not the same thing as social insurance. They are both 'transfer payments' in economic terms. The government takes money from one group, the taxpayers, and gives it to another. Insurance operates on the principle of transferring money. Dollars are taken from all exposed to a potential loss and given to the few who experience the loss. Social insurance is not a public assistance program.

In an insurance program, recipients of compensation have paid a price for it. No such payment is expected of welfare recipients. People who receive social security benefits do make contributions for the

benefits they receive, the same as any insurance program. The difference is, for low-income groups, social security benefits are disproportionately large relative to their contributions. Social security recipients do not need to demonstrate financial need to receive benefits. This is another difference between social security and public assistance. The richest contributor is entitled to benefits as well as the poorest.

Some aspects of social security resemble a welfare program. The total amount of survivor benefits a family receives after the death of the breadwinner is determined by the number of dependent children as well as the amount of social security taxes paid. In this case, the greater the need, the greater the benefits. This is an example of groups receiving more than their actuarially fair share of the benefits. For the most part,

**Differences between the Insurance Industry, Public Assistance, and Social Security**

| | Insurance Industry | Public Assistance | Social Security |
|---|---|---|---|
| Benefits can be changed | no | yes | yes |
| Mandatory program | no | no | yes |
| Supported by general tax revenues | no | yes | no |
| Program fully funded | yes | no | no |
| Actuarial prediction of losses with cost transferred to all covered | yes | no | yes |
| Value of benefits based on 'need' of recipient alone | no | yes | no |
| Benefits funded by recipient | yes | no | yes |

Social Security benefits are paid when they are earned regardless of need. Public assistance program's principle (if not the practice) is that no benefits are paid when need is lacking.

**Not Quite a Private Insurance Program**

There are important differences between a private insurance program and one operated by the state;

- With few exceptions, participation in social security is compulsory. Free choice guides decisions on private insurance purchases.
- Social security benefit levels are predetermined by law. With private insurance it is a matter of choice.
- The tax levying authority of the government backs up the social security program. It operates on a self-supporting pay-as-you-go basis. Private insurance must meet solvency requirements and be fully funded at all times. A private insurer could be liquidated and its liabilities could be met. This type of solvency has never been contemplated for the social security program.
- Social security benefits can be changed by legislative action. Private insurance agreements are contractual in nature and benefit changes require agreement by both parties.

**Social Security**

It took the Great Depression to persuade Washington that something had to be done. The Social Security Act of 1935 was a revolutionary piece of legislation. This act with its amendments and revisions affects almost everyone in the country today.

Private pension plans for employees in industry were the exception rather than the rule in the 1930s. The Social Security Act brought millions of persons under a retirement plan for the first time, creating a mammoth annuity system.

The original act levied a tax of one per cent of wages on the employee and employer to cover the employee. Payments were made to retired employees 65 or over who were covered by the system. Self-employed individuals, federal employees, and many other groups were exempt. In 1939 survivorship benefits were added. These benefits covered dependents of workers who died.

In 1965 the Social Security Act was amended to include hospital and medical insurance for the elderly

covered under Medicare. Today coverage, benefits, and taxes have increased many-fold. Almost all jobs, businesses, and professions come under the act.

Three trust funds receive the taxes collected to finance Social Security. The funds include one for old age and survivors' insurance, one for disability insurance, and one for the federal hospital insurance fund. The trust funds must be invested in obligations of the United States. The Social Security Administration is an executive agency under the Department of Health, Education, and Welfare. It administers the social insurance programs.

In addition to the federal programs directly administered by HEW, subsidies are provided for state-administered welfare. Unemployment taxes collected by the federal government are returned to the individual states for administration by the state unemployment services.

In 1975 the Social Security Act was amended to provide automatic raises in benefits. This was designed so benefits would keep up with inflation. Benefits are increased whenever the Consumer Price Index increases three per cent or more.

**A Unique Form of Insurance**

Social security is social insurance administered by the federal government. The major perils covered by social security include premature death, disability, outliving income and medical care for the elderly. Private insurance protects against the same perils. As with any insurance system the costs of the perils are transferred from the few who experience them or all who are exposed to them. The system uses the pooling technique of combining similar exposures to loss and then applying actuarial principles to predict losses in the future. When losses are accurately predicted in advance of occurrence, the system can be operated on a financially sound basis, even though it is not fully funded.

**Veterans Insurance**

The Veterans Administration operates one of the world's largest life insurance programs. It also supervises mortgage life insurance coverage for qualified disabled veterans.

World Wars I and II introduced millions to life insurance coverage who had never had it before. Life and casualty insurance companies were unable to cover war risks in 1917. Accordingly, the Bureau of War Risk Insurance was set up within the Treasury Department. It provided coverage for Army and Navy personnel using a one-year renewable term insurance plan. The original plan called for continuing the policies for five years after the signing of the peace proclamation. After five years the policies had to be converted to a permanent policy. In actuality this deadline was extended several times.

Administration of the program was transferred to the Veterans' Bureau when it was established by Congress in 1921. Permanent policies were then known as U.S. Government Life Insurance. They were made available to veterans of World War I and members of the armed forces up to a limit of $10,000. A trust fund was set up to administer the program on a legal-reserve participating basis.

This program was terminated in 1940 when the National Service Life Insurance Act established a new system. It offered voluntary life insurance for persons on active duty with the military. A National Service Life Insurance fund was established under the Treasury Department. Policies were issued on a five-year level premium plan. They were convertible into ordinary life or 20 payment or 30 payment policies. The limit of insurance to any one person was $10,000. Benefits were payable in equal monthly installments.

Some commercial insurance companies tried to discourage the veterans of World War I from converting their wartime policies. That was not the case after World War II, when insurance companies found that many veterans wanted to purchase additional private coverage. Providers of supplementary insurance to both active and retired military personnel now find a wide market for various types of policies.

**Health Insurance**

Development of health insurance in this country began more than a hundred years ago, but only reached major proportions during the Depression decade of the 1930s.

Massachusetts Health Insurance Company of Boston, organized in 1847, was the first firm to offer

insurance against the cost of medical care. In 1850 the first accident insurance was issued by the Franklin Health Assurance Company of Massachusetts.

Sickness and disability income insurance then developed, with the first individual policies to offer disability insurance appearing in 1890. Surgical and hospital expense benefits were introduced into some individual disability policies in the first decade of the twentieth century.

Most health policies before the 1930s were individual policies. At that time only 12 per cent of health care expenditures were being paid by third parties. Today 70 per cent of health care is handled on a third-party basis.

Blue Cross-Blue Shield hospital and medical coverage launched large-scale group health insurance in the 1930s. During the 1940s, Aetna and other established companies entered the field. Liberty Mutual Insurance Company in 1949 issued the first major medical expense type policy, covering families against catastrophic illness which involved prolonged heavy medical costs.

Life span extension provided by twentieth century improvements in medical care resulted in a growing number of senior citizens in need of that care during retirement. Massive federal and state programs of Medicare and Medicaid began in the 1960s for the elderly and those below the poverty line. Employers encouraged by tax inducements also have extended health care coverage to millions of workers.

**Who is Eligible for Medicare?**
Generally, a person is eligible for Medicare if that person or his/her spouse worked for at least 10 years in Medicare-covered employment and is 65 years old and a citizen or permanent resident of the United States. One might also qualify for coverage if they are a younger person with a disability or with chronic kidney disease.

Here are some simple guidelines. Part A is available at age 65 without having to pay premiums if a person:

- is already receiving retirement benefits from Social Security or the Railroad Retirement Board.
- is eligible to receive Social Security or Railroad benefits but have not yet filed for them.
- (or spouse) had Medicare-covered government employment.

If under 65, one can get Part A without having to pay premiums if:

- Receiving Social Security or Railroad Retirement Board disability benefits for 24 months.
- Someone is a kidney dialysis or kidney transplant patient.

While individuals do not have to pay a premium for Part A if they meet one of those conditions, they still must pay for Part B if it is wanted. The Part B monthly premium in 2017 is $134.00. It is deducted from the Social Security, Railroad Retirement, or Civil Service Retirement check.

**Enrollment**
Enrollment in Medicare is handled in two ways: either people are enrolled automatically or individuals have to apply. Here is how it works.

**Automatic Enrollment**
If a person is not yet 65 and already getting Social Security or Railroad Retirement benefits, he or she does not have to apply for Medicare. They are enrolled automatically in both Part A and Part B and their Medicare card is mailed about 3 months before the 65th birthday. If someone does not want Part B, he or she can follow the instructions that come with the card.
If an individual is disabled, that person will be automatically enrolled in both Part A and Part B of Medicare beginning in the 25th month of disability. The card will be mailed about 3 months before the person is entitled to Medicare.

**Applying for Medicare**
A person needs to apply for Medicare if not receiving Social Security or Railroad Retirement Benefits three months before he or she turns 65, or if a person requires regular dialysis or kidney transplant. That is the beginning of the 7-month initial enrollment period. By applying early, people will avoid a possible delay in the start of Part B coverage. One applies by contacting any Social Security Administration office.

If a person does not enroll during this 7-month period, he or she will have to wait to enroll until the next general enrollment period. General enrollment periods are held January 1 to March 31 of each year, and Part B coverage starts the following July.

There is no reason to put off enrolling. If someone waits 12 or more months to sign up, his or her premiums generally will be higher. Part B premiums go up 10 percent for each 12 months that one could have enrolled but did not. The increase in the Part A premium (if a person has to pay a premium) is 10 percent no matter how late an individual enrolls for coverage.

Under certain circumstances, however, an applicant can delay Part B enrollment without having to pay higher premiums. If a person is age 65 or over and has group health insurance based on the individual's or their spouse's current employment, or if he or she is disabled and has group health insurance based on current employment or the current employment of any family member, these choices are available:

- The person may enroll in Part B at any time while covered by the group health plan; or,
- The individual can enroll in Part B during the 8-month enrollment period that begins the month employment ends or the month he or she is no longer covered under the employer plan, whichever comes first.

If one enrolls in Part B while covered by an employer plan or during the first full month when not covered by that plan, coverage begins the first day of the month one enrolls. A person also has the option of delaying coverage until the first day of the following 3 months. If a person enrolls during any of the 7 remaining months of the special enrollment period, coverage begins the month after enrollment.

If a person does not enroll by the end of the 8-month period, he or she will have to wait until the next general enrollment period, which begins January 1 of the next year.

Even if an individual continues to work after age 65, he or she should sign up for Part A of Medicare. Part A may help pay some of the costs not covered by the employer plan. It may not, however, be advisable to sign up for Part B if the person has health insurance through their employer. The monthly Part B premium would still have to be paid, and the Part B benefits may be of limited value as long as the employer plan was the primary payer of the over-65 employee's medical bills. Moreover, this would trigger the 6-month Medigap open enrollment period (see Medigap Insurance).

**Data Matching**

Medicare is now enabled by law to get accurate information about health insurance held by beneficiaries. The Health Care Financing Administration, the agency that administers the Medicare program, is authorized along with the Internal Revenue Service and the Social Security Administration to share information about whether Medicare beneficiaries or their spouses are working and have employment-related health insurance.

This process, called Data Match, is expected to help Medicare find cases where another insurer should have paid first on health care claims by Medicare beneficiaries. Employers will be contacted by designated Medicare contractors to confirm health coverage information. It has been estimated that this law will help Medicare get back an estimated $1 billion in taxpayer funds.

The government must act under specific guidelines to protect individuals' privacy. It must tell individuals at the time the information is collected why it is needed and how it will be used. It must make sure personal information is used only for the reasons given, or get permission to use it for another purpose. It must allow the individual to see records and have the opportunity to correct inaccuracies.

**Medicare Coverage**

The Medicare program has two parts. Hospital Insurance (Part A) helps pay for hospital care, nursing facility or home health care under some conditions, and hospice care. Medical Insurance (Part B) helps pay for doctors' services and other outpatient care not covered by Part A.

**Hospital Insurance (Part A)**

Medicare hospital insurance helps pay for necessary medical care and services furnished by Medicare-certified hospitals, skilled nursing facilities, home health agencies, and hospices.

The number of days that Medicare covers care in hospitals and skilled nursing facilities is measured in benefit periods. A benefit period begins on the first day a person receives services as a patient in a hospital or skilled nursing facility and ends after he or she has been out of the hospital or skilled nursing facility and has not received skilled care in any other facility for 60 days in a row. There is no limit to the number of benefit periods a person can have.

Those eligible for premium-free Medicare Part A benefits generally are people 65 and over who receive or are eligible for Social Security benefits. Eligibility generally requires ten years of employment covered by Social Security by the individual or spouse.

Medicare Part B requires payment of monthly premiums. People under 65 may qualify for Part A benefits if they are receiving Social Security payments for disability or if they receive dialysis for permanent kidney failure.

Those who are 65 or older and not otherwise eligible may be able to buy Medicare protection by paying premiums.

**Major Services**
These are the major services covered under Medicare Part A for a hospital inpatient:

- A semiprivate room (two to four beds).
- All meals, including special diets.
- Regular nursing services.
- Costs of special units such as intensive care or coronary care.
- Drugs furnished by the hospital.
- Blood transfusions furnished by the hospital.

**What Medicare Does Not Cover**
Some hospital services are not included under Medicare. They include:

- Personal conveniences requested, such as a telephone or television in the hospital room.
- Private duty nursing.
- Extra charges for a private rooms unless it is a medical necessity.

Part A Medicare covers a benefit period from the first through the 60th day of hospitalization. All eligible services are paid for by Medicare during that period except for the first $1,316 (in 2017). This is the inpatient hospital deductible. It may be charged by the hospital only for the first admission in each benefit period. If the patient is discharged and readmitted before the end of the benefit period, another deductible does not apply.

If the hospital stay runs longer than 60 days, Part A of Medicare pays for all covered services from the 61st through the 90th day except for $329 (in 2017) a day. This amount is called co-insurance and is charged for by the hospital.

If more than 90 days of hospitalization are needed in one benefit period, they can come out of lifetime reserve days, of which each patient has 60 in a lifetime. Medicare pays for coverage during reserve days except for $658 (in 2017) for each reserve day used. A patient who does not wish to use reserve days must tell the hospital so in writing.

The Medicare system now requires that a patient be given written information about the right to make decisions regarding medical care, or to name someone to make those choices under a living will or a durable power of attorney for health care. State laws govern the details of these provisions.

**Skilled Nursing Facilities**
To be approved by Medicare as a Skilled Nursing Facility a provider must have specially qualified staff and equipment to offer skilled nursing care or rehabilitation and other related health services. This care can only be performed by or under the supervision of licensed nursing personnel. Simple custodial care does not qualify. Thus not all nursing homes are Skilled Nursing Facilities. Sometimes only parts of a facility will be

devoted to skilled nursing care.

In an approved facility, six conditions must be met for a patient to qualify under Medicare rules:

- The condition of the patient must require daily skilled nursing or skilled rehabilitation services.
- The patient must have been in a hospital at least three days in a row, not counting the day of discharge, before being admitted to the Skilled Nursing Facility.
- The patient must be admitted to the facility within a short time, generally within 30 days, after leaving the hospital.
- The care must be for a condition that was treated in the hospital, or for a condition that arose during treatment in the facility for a condition treated in the hospital.
- A medical professional must certify that the patient needs and receives skilled nursing or rehabilitation services daily.
- The stay is approved by the Medicare intermediary handling Part A claims.

Part A pays for all covered services in a Skilled Nursing Facility for the first 20 days. During the 21st through the 100th day, Part A pays for all covered services except for a co-insurance amount of $164.50 a day (in 2017).

**Home Health Care**

If skilled health care is needed by a patient at home, Medicare will pay provided the services are furnished by a participating home health agency. Services include intermittent skilled nursing care, physical therapy, or speech therapy. The patient must be homebound and under the care of a physician who sets up an approved plan.

The nursing care can include eight hours of reasonable and necessary care per day for up to 21 consecutive days, or longer in certain circumstances. Medicare also pays for occupational therapy, part-time services of home health aides, medical social services, medical supplies, and 80 per cent of approved durable medical equipment.

Home health care services not covered by Medicare include 24-hour nursing care at home, drugs and biologicals, meals delivered to the home, homemaker services, and blood transfusions.

**Hospice Care**

A special type of service for terminally ill patients is known as hospice care. It is available as both home care and inpatient care, providing pain relief, symptom management, and support services. The hospice benefit under Medicare includes services every day and needed custodial care such as homemaker services and counseling. A doctor must certify that the patient is terminally ill. Care must be provided by a hospice program participating in Medicare.

There are no deductibles under hospice care, only small coinsurance amounts for outpatient drugs and inpatient respite care. This is a short-term stay in a facility to give temporary relief to the person regularly assisting with home care.

The Medicare hospice benefit pays only for treatments for pain relief and symptom management of a terminal illness. Treatments not related to the terminal illness usually can come under regular Medicare.

Under the law, Medicare cannot pay for services performed by immediate relatives or members of the patient's household, or for services paid for by another government program.

**Medicare Part B**

**Medical Insurance (Part B)**

Medicare Part B helps pay for doctor's services, outpatient hospital services (including emergency room visits), ambulance transportation, diagnostic tests, laboratory services, some preventive care like mammography and Pap smear screening, outpatient therapy services, durable medical equipment and supplies, and a variety of other health services. Part B also pays for home health care services for which Part A does not pay.

Medicare Part B pays 80 percent of approved charges for most covered services. The Medicare

beneficiary is responsible for paying a $100 deductible per calendar year and the remaining 20 percent of the Medicare approved charge. A person will have to pay limited additional charges if the doctor who cares for an individual does not accept assignment. This means the doctor does not agree to accept the Medicare approved charge for services. Doctors' services covered by Medicare Part B include:

- •Medical and surgical services
- •Diagnostic tests that are part of the patient's treatment
- •Radiology and pathology services for hospital inpatient or outpatient treatment
- •Treatment for mental illness in a hospital facility or on a limited basis as an outpatient
- •Other services such as X-rays, services provided by the doctor's office nurse, drugs that cannot be self-administered, blood transfusions, medical supplies, physical or occupational therapy and speech pathology services.

Some services are not covered by Medicare. They include:

- Routine physical examinations and tests for such examinations, except for some Pap smears and mammograms
- Routine foot and dental care
- Routine examinations for eyeglasses
- Routine auditory exams or hearing aids
- Routine immunizations
- Cosmetic surgery unless needed because of accidental injury or malformation of part of the body.

**Qualified Services**

In addition to services by doctors of medicine and doctors of osteopathy, some care by other providers is covered under Medicare. These include chiropractors, podiatrists, dentists, and optometrists. The only kind of chiropractic care covered by Medicare is manual manipulation of the spine to correct a subluxation shown by X-ray. This must be done by a licensed chiropractor. Medicare does not cover other diagnostic services or treatment provided by a chiropractor, including X-rays.

Licensed podiatrists can provide Medicare-approved treatment for injuries and diseases of the foot, such as ingrown toenails, hammer toes, bunion deformities, and heel spurs. Routine foot care such as removal of corns and trimming of nails is not covered unless the patient is being treated by a medical doctor for a condition affecting the legs or feet such as diabetes or peripheral vascular disease.

**Dental Care**

Medicare does not cover dental treatment or surgery involving the teeth or structures directly supporting the teeth. Dental care in certain cases when the medical problem is more extensive may come under Medicare. In case hospitalization is needed because of a dental procedure, Medicare Part A will pay for the hospital stay even if the dental care does not come under Medicare Part B.

**Eye Care**

Medicare coverage may include the services of a licensed optometrist in some cases, but not routine eye exams and usually not eyeglasses. Spectacles or lenses made necessary by cataract surgery will be covered by Medicare.

**Second Opinion**

Patients are encouraged to seek second opinions in case of recommended surgery. Medicare will help pay for a second opinion and for a third opinion in case the first two contradict each other. A Medicare Part B carrier can provide names and phone numbers of area doctors who provide second opinions.

**Other Practitioners**

Services from some qualified practitioners who are not physicians may be approved by Medicare. These may include a certified registered nurse anesthetists, certified nurse midwife, clinical psychologist, clinical social worker, physician assistant, and nurse practitioner.

Outpatient hospital services are covered under Medicare Plan B, even from a non-participating hospital in some emergency cases. The annual Plan B deductible of $100 a year and co-insurance of 20 per cent above the hospital charge apply. If the hospital cannot tell whether a patient's deductible has been met and asks for payment of the entire bill, any overpayment will be refunded by Medicare. Covered outpatient services include

◆Emergency room or outpatient clinic services, including same-day surgery
◆Laboratory tests
◆Mental health care in a partial hospital program if a doctor certifies that without it, inpatient treatment would be required.
◆Medical supplies, drugs, and blood transfusions.

Under both Medicare Plan A and Plan B, there is a deductible for the first three units provided in a blood transfusion.

**Out-of-Pocket Expenses**
Medicare does not pay all the health care costs of the elderly. They still have out-of-pocket expenses for co-payments and deductibles, custodial nursing home care, eyeglasses, prescriptions, and other expenses not covered by the government programs.

Supplemental medical coverage, which pays for expenses not included in Medicare, is now a major part of the insurance business. Public awareness of the need for health insurance protection has never been higher.
Even with Medicare, Medicaid, employer-sponsored group insurance, indigent health care for people who are not even citizens, and other types of coverage, some political voices continue to maintain that. "An estimated one-third of U.S. citizens still have no health insurance." A national health program is an item high on the political agenda for those factions.

**Fee Schedules**
Along with deductibles and co- insurance, excess charges by health care providers under Medicare Plan B make up much of the out-of-pocket expense total for the elderly. Medicare sets a scheduled amount of which it will pay 80 per cent to the doctor or other provider. Anything over that is an excess charge for which the patient is billed. Numerical values were assigned to all services performed by doctors under the new fee schedule. A standard conversion factor is set to arrive at the cost of a particular service when multiplied by the numerical value assigned to the service.

The main purpose of setting up and revising fee schedules is to increase payments to family doctors and general practitioners, while slowing the increase in fees to specialists. The overall budget for Medicare rose from $138 billion in 1992 to a $540 billion in 2015, an overall increase of 291% or about 5.9% annually.

**Other Medicare Health Plan Choices**
Beneficiaries may have other Medicare health plan choices available to them. To be eligible for these other health plan choices, a person must:
- Have both Part A (hospital insurance) and Part B (medical insurance).
- Continue to pay the monthly Part B premium.
- Live in the plan's service area (the counties in which the plan is offered).
- Not have permanent kidney failure (End-Stage Renal Disease).

## Part C: Medicare Advantage plans
With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans, instead of through the original Medicare plan (Parts A and B). These programs were known as "Medicare+Choice" or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, "Medicare+Choice" plans were made more attractive to Medicare beneficiaries by the addition of prescription drug coverage and became known as "Medicare Advantage" (MA) plans. Traditional or "fee-for-service" Medicare has a standard benefit package that covers medically necessary care members can receive from nearly any hospital or doctor in the country. For people who choose to enroll in a Medicare Advantage health plan, Medicare pays the private health plan a capitated rate, or a set amount, every month for each member. Members typically also pay a monthly premium in addition to the Medicare Part B premium to cover items not covered by traditional Medicare (Parts A & B), such as prescription drugs, dental care, vision care and gym or health club memberships. In exchange for these extra benefits, enrollees may be limited in the providers from whom they can receive services without paying extra. Typically, the plans have a "network" of providers that patients can use. Going outside that network may

require permission or extra fees.

Medicare Advantage plans are required to offer coverage that meets or exceeds the standards set by the original Medicare program, but they do not have to cover every benefit in the same way. If a plan chooses to pay less than Medicare for some benefits, like skilled nursing facility care, the savings may be passed along to consumers by offering lower copayments for doctor visits. Medicare Advantage plans use a portion of the payments they receive from the government for each enrollee to offer supplemental benefits. Some plans limit their members' annual out-of-pocket spending on medical care, providing insurance against catastrophic costs over $5,000, for example. Many plans offer dental coverage, vision coverage and other services not covered by Medicare Parts A or B, which makes them a good value for the health care dollar, if the insured wants to use the provider included in the plan's network or "panel" of providers.

Medicare Advantage members receive additional coverage and medical benefits not enjoyed by traditional Medicare members, and savings generated by Medicare Advantage plans may be passed on to beneficiaries to lower their overall health care costs. Other important distinctions between Medicare Advantage and traditional Medicare are that Medicare Advantage health plans encourage preventive care and wellness and closely coordinate patient care. As with other facets of the Medicare program, the Medicare.gov website devotes several web pages to this topic.

Medicare Advantage Plans that also include Part D prescription drug benefits are known as a Medicare Advantage Prescription Drug plan or a MA-PD.

In 2016, the majority of the 57 million people on Medicare were covered by traditional Medicare, with 31% enrolled in a Medicare Advantage plan. Since 2004, the number of beneficiaries enrolled in private plans has more than tripled from 5.3 million to 17.6 million in 2016. The share of beneficiaries enrolled in private plans varies by state, ranging from 55% in Minnesota to less than 1% in Alaska. Since 2010 when the Affordable Care Act (ACA) was established, many have been interested in the effects of the ACA phasing down federal payments to Medicare Advantage plans. More recently, proposed mergers between health insurance firms with large footprints in Medicare Advantage have raised questions about how the mergers could affect beneficiaries (Medicare Advantage 2016 Data Spotlight, Kaiser Foundation website).

**Part D: Prescription Drug plans**
Medicare Part D went into effect on January 1, 2006. Anyone with Part A or B is eligible for Part D. It was made possible by the passage of the Medicare Prescription Drug, Improvement, and Modernization Act. In order to receive this benefit, a person with Medicare must enroll in a stand-alone Prescription Drug Plan (PDP) or Medicare Advantage plan with prescription drug coverage (MA-PD). These plans are approved and regulated by the Medicare program, but are actually designed and administered by private health insurance companies. Unlike Original Medicare (Part A and B), Part D coverage is not standardized. Plans choose which drugs (or even classes of drugs) they wish to cover, at what level (or tier) they wish to cover it, and are free to choose not to cover some drugs at all. The exception to this is drugs that Medicare specifically excludes from coverage, including but not limited to benzodiazepines, cough suppressant and barbiturates. Plans that cover excluded drugs are not allowed to pass those costs on to Medicare, and plans are required to repay CMS if they are found to have billed Medicare in these cases. Note that for beneficiaries who are dual-eligible (Medicare and Medi-Cal eligible) Medi-Cal may pay for drugs not covered by part D of Medicare, such as benzodiazepines, and other restricted controlled substances.

Neither Part A nor Part B pays for all of a covered person's medical costs. The program contains premiums, deductibles and coinsurance, which the covered individual must pay out-of-pocket. Some people may qualify to have other governmental programs (such as Medicaid) pay premiums and some or all of the costs associated with Medicare.

**Eligibility and enrollment**
Individuals are eligible for prescription drug coverage under a Part D plan if they are entitled to benefits under Medicare Part A and/or enrolled in Part B. Beneficiaries can obtain the Part D drug benefit through two types of private plans: they can join a Prescription Drug Plan (PDP) for drug coverage only or they can join a Medicare Advantage plan (MA) that covers both medical services and prescription drugs (MA-PD). The latter type of plan is actually part of Medicare Part C and has several other differences relative to original Medicare. About two-thirds of Part D beneficiaries are enrolled in a PDP option. Not all drugs

will be covered at the same level, giving participants incentives to choose certain drugs over others. This is often implemented via a system of tiered formularies in which lower-cost drugs are assigned to lower tiers and thus are easier to prescribe or cheaper.[2]

**Other Insurance Sometimes Pays Before Medicare**

Some people who have Medicare have other insurance (not including Medigap policies) that must pay before Medicare pays its share of their bill. Other insurance pays first if:

- A person is are 65 or older; (b) an individual or spouse is currently working at an employer with 20 or more employees; and (c) the person has group health insurance based on that employment.
- Someone is under age 65 and is disabled; (b) that person or any member of the family is currently working at an employer with 100 or more employees; and (c) the individual has group health insurance based on that employment.
- An individual has Medicare because of permanent kidney failure.
- A person has an illness or injury that is covered under workers' compensation, the federal black lung program, no-fault insurance, or any liability insurance.

If a Medicare beneficiary matches any of these descriptions and has other insurance along with Medicare, the other insurance will often be the first payer on the health claims. One should tell the doctor, hospital, and all other providers of services about the other insurance. Claims can then be sent to the right insurer first.

**Medigap Insurance Products**

Though Medicare covers many health care costs, people will still have to pay Medicare's coinsurance and deductibles. There are also many medical services that Medicare does not cover.

Medicare supplement insurance was owned by about two-thirds of Medicare recipients by the end of the 1980s. It was estimated that about 15% of them had been induced to buy multiple policies that provided no extra benefits. Congress moved to reform conditions in the Medigap field with provisions in the Omnibus Budget Reconciliation Act of 1990. This law required states to adopt a simplification plan for Medigap policies under which only ten standardized types of coverage could be offered by private insurers (See Chart 7A).

Individuals may want to buy a Medicare supplemental insurance (Medigap) policy. Medigap is private insurance that is designed to help pay Medicare cost-sharing amounts. There are 10 standard Medigap policies, and each offers a different combination of benefits.

For a period of 6 months from the date one is are first enrolled in Medicare Part B and is age 65 or older, he or she has a right to buy the Medigap policy of their choice. The best time to buy a policy is during the Medigap open enrollment period.

A person cannot be turned down or charged higher premiums because of poor health if he or she buys a policy during this period. Once the Medigap open enrollment period ends, a person may not be able to buy the policy of their choice. He or she may have to accept whatever Medigap policy an insurance company is willing to sell.

If someone has Medicare Part B but is not yet 65, the 6-month Medigap open enrollment period begins when upon turning 65. However, several states (Connecticut, Maine, Massachusetts, Minnesota, New Jersey, New York, Oklahoma, Oregon, Pennsylvania, Virginia, Washington, and Wisconsin) require at least a limited Medigap open enrollment period for Medicare beneficiaries under 65.

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[2] J Hoadley et al, "Medicare Part D Spotlight: Part D Plan Availability in 2010" Kaiser Foundation website

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The individual state health insurance assistance programs can answer questions about Medicare and other health insurance. The services are free. A person can get help in deciding whether more insurance is needed and, if so, what kind and how much to buy.

The state assistance programs also provide information about Medicare SELECT, another type of Medicare supplemental health insurance sold by insurance companies and HMOs throughout most of the country. Medicare SELECT is the same as standard Medigap insurance in nearly all respects. The only difference between Medicare SELECT and standard Medigap insurance is that each insurer has specific hospitals, and in some cases specific doctors, that must be used, except in an emergency, in order to be eligible for full benefits. Medicare SELECT policies generally have lower premiums than other Medigap policies because of this requirement

Suspected violations of the laws governing the marketing and sales of Medigap and other types of insurance policies should generally be reported to the state insurance department.

Private health insurance is available through group and individual policies. It is offered by some companies through agents and by other companies directly through advertising media and mail. The extent of coverage differs widely among both group and individual policies.

Medicare supplement insurance offered by private companies in what generally is called Medigap coverage has grown into a multi-billion dollar industry. Such policies basically cover deductions and co-payments required by Medicare. Some have additional provisions.

States were required to adopt a simplification plan for Medigap policies under which only ten standardized types of coverage could be offered by private insurance carriers. This plan was agreed on by the National Association of Insurance Commissioners, made up of heads of insurance administration from all 50 states. Each state could choose to approve all ten plans or could select specific plans. Thus not all plans are available in all states.

## Chart 7A

Every company offering Medigap insurance must offer Plan A. In addition, companies may have some, all, or none of the other plans.

| | Medicare Supplement Insurance (Medigap) Plans | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefits** | **A** | **B** | **C** | **D** | **F*** | **G** | **K** | **L** | **M** | **N** |
| Medicare Part A coinsurance and hospital costs (up to an additional 365 days after Medicare benefits are used) | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Medicare Part B coinsurance or copayment | 100% | 100% | 100% | 100% | 100% | 100% | 50% | 75% | 100% | 100% *** |
| Blood (first 3 pints) | 100% | 100% | 100% | 100% | 100% | 100% | 50% | 75% | 100% | 100% |
| Part A hospice care coinsurance or copayment | 100% | 100% | 100% | 100% | 100% | 100% | 50% | 75% | 100% | 100% |
| Skilled nursing facility care coinsurance | | | 100% | 100% | 100% | 100% | 50% | 75% | 100% | 100% |
| Part A deductible | | 100% | 100% | 100% | 100% | 100% | 50% | 75% | 50% | 100% |
| Part B deductible | | | 100% | | 100% | | | | | |
| Part B excess charges | | | | | 100% | 100% | | | | |
| Foreign travel emergency (up to plan limits) | | | 80% | 80% | 80% | 80% | | | 80% | 80% |
| | | | | | | | Out-of-pocket limit in 2019** | | | |
| | | | | | | | $5,560 | $2,780 | | |

* Plan F is also offered as a high-deductible plan by some insurance companies in some states. If you choose this option, this means you must pay for Medicare-covered costs (coinsurance, copayments, deductibles) up to the deductible amount of $2,300 in 2019 before your policy pays anything.
**For Plans K and L, after you meet your out-of-pocket yearly limit and your yearly Part B deductible ($185 in 2019), the Medigap plan pays 100% of covered services for the rest of the calendar year.
*** Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that don't result in an inpatient admission.
This chart shows basic information about the different benefits that Medigap policies cover. If a percentage appears, the Medigap plan covers that percentage of the benefit, and you must pay the rest.

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**Plans Offered**

Provisions of the ten standardized plans are outlined under letters of the alphabet, A through J. All ten types include the basic benefits, which are the only ones offered under Plan A. Medicare supplement insurance is regulated by federal and state law. It provides specific benefits that help fill the gaps in Medicare coverage. Other kinds of insurance may help with out-of-pocket health care costs (like LTC coverage), but they do not qualify as so-called Medigap plans. To make it easier to compare policies, the number of different Medigap policies that can be sold is limited to ten standard plans. The standard plans and benefits are shown in Chart 7A.

**Marketing Rules**
Policies sold by direct marketing must be approved by individual states in which they are sold. Some states have more stringent regulations than those do in the federal regulations.

It is unlawful for a company or agents to suggest that they represent the Medicare program or any government agency. Medicare beneficiaries who believe they have been victimized through these illegal sales practices have recourse through their state board of insurance or the U.S. Department of Health and Human Services.

Federal law now also prohibits the use of any governmental identifying marks and names or variations of them to falsely claim or suggest that the governmental agencies have approved, endorsed or authorized any item, including insurance policies. It is illegal to use designs that look as if they came from the government—with eagles and official-sounding government bureaus on the return address.

An advertisement aimed primarily at senior citizens may not be captioned "Important Notice." Terms like "100 per cent," "unlimited," "as high as" and "this policy will pay your hospital and surgical bills" may not be used to exaggerate policy benefits. Ads must accurately describe the negative features of limitations, exclusions or benefits reductions in a policy.

When a celebrity is paid to endorse an insurance policy the ad must include the words "Paid Endorsement." The ad also must disclose any financial interest the celebrity might have in the company, such as membership on its board of directors. An ad must tell the applicant about the Medicare benefits (Medicare hospital insurance and/or Medicare medical insurance), whichever the policy is designed to supplement. An advertisement used primarily as a source of leads for selling insurance must say so.

There are penalties for claiming that a policy meets legal standards for certification when it does not, and for using the mail for the delivery of advertisements of Medicare supplement health insurance policies that have not been approved for sale in the state.

**Enrollment Opportunities**
An open enrollment provision in the federal regulations for Medigap policies requires insurers to offer coverage to individuals for a six-month period after they reach 65. People of working age who are enrolled in Part B of Medicare also have six months of open enrollment available on private policies. The insurer cannot charge higher prices for this provision.

The law requires insurers to pay at least 65 cents in benefits for each premium dollar received on individual policies and 75 cents on group contracts. Penalties are provided for insurers and agents violating any of these federal rules.

**Prepayment Plans**
There are prepayment plans such as a health maintenance organization (HMO) or competitive medical plan (CMP) which participate in the Medicare program. Prepayment plans both insure health care and provide health care services. People who join are required to receive health services directly from physicians and other providers affiliated with the plan, except in an emergency.

If the Medicare beneficiary enrolls in a prepayment plan, Medicare pays the plan a fixed amount each month to provide the person with all Medicare approved services. The enrollee may be required to pay the plan a monthly premium to cover the cost of deductibles and co-payments that would be the beneficiary's

responsibility under Medicare if other than the prepayment group were being used.

However, depending on the plan, there may not be an extra premium and the plan may offer services beyond those covered by Medicare. Services are prepaid, so there are usually no claims forms to process. With enrollment into a prepayment plan there is no need for a Medicare supplement insurance policy.

**Employer Group Insurance**
Many people are covered by a group plan while they are employed. Some group coverage can be continued or converted to a suitable individual Medicare supplement policy when age 65 is reached by the employee. Employer group insurance that is continued or converted after retirement usually has the advantage of having no waiting periods or preexisting condition exclusions.

On group policies, if a contract is terminated, members now must be offered conversion from group to individual policies.

**Medicare as Supplement Insurance**
If a worker is 65 or older and insured by an employer health plan, the worker must use the employer's plan as primary health insurance. The employer's plan will be the primary payer of the hospital and medical bills and Medicare will be the secondary payer.

If the employer's plan does not pay all of the charges, Medicare will help pay some of the cost for Medicare-covered services. The employer may also offer a plan that pays for health care services not covered by Medicare, such as hearing aids and routine dental care and physicals.

**Association Group Insurance**
Many organizations, other than employers, offer various kinds of group health insurance coverage to their members over age 65. AARP is an example of such an Association.

**Specialized Policies**
Some types of coverage are generally limited in scope and are not substitutes for Medicare supplement insurance, prepayment plans, or long-term care insurance.

**Nursing Home Coverage**
Most people who enter nursing homes do so to receive custodial care, which is not covered by Medicare or most Medicare supplement policies. The only care in nursing homes that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a Skilled Nursing Facility.

To qualify for Medicare coverage for Skilled Nursing Facility care, the primary need must be for daily skilled nursing or skilled rehabilitation therapy at least five times per week. The daily skilled services must be those which, as a practical matter, can only be provided on an inpatient basis. The services must also be provided in a Medicare-certified Skilled Nursing Facility.

When Medicare coverage for Skilled Nursing Facility care ends because the patient no longer requires this level or intensity of care, coverage under Medicare supplement policies also stops. Neither Medicare nor Medicare supplement policies will cover SNF care for stays longer than 100 days.

There are, however, insurance policies that can be purchased to cover custodial care, care in an intermediate care facility, or Skilled Nursing Facility care beyond that covered by Medicare. The coverage is offered through a long-term care policy. Many new long-term care insurance products have been coming into the market in the last few years. Some of them offer considerably better coverage than the older types of nursing home insurance, which used to be the only coverage available. Some of the newer types of long term care policies will also cover some in-home care beyond that which Medicare provides under the Home Health benefit.

**Hospital Confinement Indemnity Coverage**
Indemnity coverage pays a fixed amount for each day the insured is hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits.

**Specified Disease Coverage**
(Not available in all states). This coverage provides benefits for only a single disease, such as cancer, or a group of specified diseases. The value of such coverage depends on the chance the insured will get the specific disease or diseases covered. Benefits usually are limited to payment of a fixed amount for each type of treatment and are not designed to fill the Medicare gaps.

**Medicaid**

This is an assistance program designed by the federal government and administered by individual states within federal guidelines. It is for some people age 65 or older, people who are blind, people with other disabilities, members of poor families with dependent children, and certain pregnant women. The program is known as Medi-Cal in California. Medicaid could be looked at as supplementary insurance for the underprivileged. It can pick up where Medicare leaves off. For instance, Medicaid can pay deductibles for hospital and medical costs, and the co-insurance part of medical charges not covered by Medicare.

In some states, Medicaid will pay the Medicare beneficiary's Part B medical insurance premiums. Eligibility requirements vary among states. Medicaid is applied for at the state or local welfare office.

Medicaid will generally pay for long-term care if you have very little income and few assets. A person probably should not buy a supplemental policy if he or she is eligible for Medicaid. Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services. When Medicaid pays the spouse's nursing home bills, a person is allowed to the couple's house and furniture, a living allowance, and some of their joint assets. The choice of long-term care services will be limited if an individual is receiving Medicaid. To learn more about Medicaid, the local or state Medicaid agency can be contacted.

**Resource (Asset) Rules**
These are general federal guidelines. The specific rules for individual states may differ somewhat.

In order to be eligible for Medicaid benefits a nursing home resident may have no more than $2,000 in "countable" assets. The spouse of a nursing home resident--called the 'community spouse'-- is limited to one half of the couple's joint assets up to $120,900 (in 2017) in "countable" assets. This figure changes each year to reflect inflation. In addition, the community spouse may keep $24,180 (in 2017), even if that is more than half of the couple's assets. This figure is higher in some states.
All assets are counted against these limits unless the assets fall within the short list of "noncountable" assets. These include:
(1) personal possessions, such as clothing, furniture, and jewelry;
(2) one motor vehicle, valued up to $4,500 for unmarried recipients and of any value for the healthy (community) spouse;
(3) the applicant's principal residence, provided it is in the same state in which the individual is applying for coverage (the states vary in whether the Medicaid applicant must prove a reasonable likelihood of being able to return home); Under the Deficit Reduction Act of 2005 (DRA), principal residences may be deemed noncountable only to the extent their equity is less than $560,000, with the states having the option of raising this limit to $840,000 (in 2017). In all states and under the DRA, the house may be kept with no equity limit if the Medicaid applicant's spouse or another dependent relative lives there.
(4) prepaid funeral plans and a small amount of life insurance; and
(5) assets that are considered "inaccessible" for one reason or another.

**The Home**
Depending on the state, nursing home residents do not have to sell their homes in order to qualify for Medicaid. In some states, the home will not be considered a countable asset for Medicaid eligibility purposes as long as the nursing home resident *intends* to return home; in other states, the nursing home resident must prove a *likelihood* of returning home. In all states, the house may be kept if the Medicaid applicant's spouse or another dependent relative lives there.

**Government Regulation & Insurance**
Because of the basic role insurance plays in the economy of the nation, government regulation of the private insurance industry is far-reaching. In early insurance development states supervised records primarily for

tax purposes. The case of Paul v. Virginia, taken to the U.S. Supreme Court in 1896 when an agent of a New York company refused to procure a license in Virginia, established the right of individual states to regulate insurance companies.

On the basis of a 1914 case, German Alliance Insurance Company v. Lewis, involving the right of the state of Kansas to regulate rates, the Supreme Court held that the insurance business was vested with the public interest and was therefore subject to government regulation.

Public policy objectives were seen as stemming from a 1934 decision of the court, Nebbis v. New York. These included preserving and enhancing solvency of insurance companies, promoting fair and adequate premium rates, ensuring fairness, and fulfilling social goals beyond those of simply operating a successful insurance business.

A 1944 decision of the Supreme Court shook the insurance industry when it appeared the long-standing doctrine of state regulation would be struck down. The South-Eastern Underwriters Association, a rate-making body for fire insurance, was indicted for violation of the Sherman Antitrust Act along with its member companies and a number of individuals. The act provided penalties for price-fixing in interstate commerce.

When the case was carried to the Supreme Court, two justices disqualified themselves, four said the indictment was valid, and three dissented. The decision held that insurance was commerce and when it crossed state lines it was interstate commerce.

There was an outcry from insurance industry figures, who objected to the striking down of traditional state regulation in a decision by less than a majority of the entire court. Congress came to the rescue. The McCarran-Ferguson Act in 1945 in effect exempted the insurance business from federal antitrust regulation.

The law required, however, that states actively supervise the insurance business and not ignore unfair intercompany agreements.

The 1945 act, still in effect in amended form, allows insurance companies operating in various states to pool statistical data for rate making. They may also use standard policy forms and standardized coverage and employ joint underwriting and reinsurance procedures including pools for exceptional hazards. The law also authorizes tying of various insurance lines by making the purchase of unprofitable lines of insurance conditional on the purchase of profitable lines.

**NAIC Regulation**

Modern regulation by states, replacing the simple collection of information for tax purposes, began when Elizur Wright became insurance commissioner in Massachusetts in 1858. He had devoted himself for years to the study of insurance statistics, and he succeeded in having a law passed that required net premium reserves for life insurance companies. The law gave state insurance commissioners the power to calculate adequate reserves through the use of mortality tables and interest rate information.

This legislation was the basis of modern legal reserve requirements as a test of solvency for life insurance companies. The Massachusetts reform also set the precedent of published reports containing financial statements of insurance companies.

New York was the next state to establish a separate insurance department. Boards were set up in several other states during the 1860s with powers of more than formal supervision over the insurance business.

As communication facilities improved and insurance companies expanded their business over several states, cooperation between administrators of the various state boards became necessary. In 1871 the National Convention of Insurance Commissioners was formed. This is the organization now known as the National Association of Insurance Commissioners, or NAIC, made up of the insurance commission heads of all states. It holds regular meetings and has committees to handle continuous oversight of state insurance regulations.

Although the NAIC itself has no legal power, it studies problems in the insurance industry as they develop and recommends appropriate state legislation in order to keep regulations as uniform as possible. Individual commissioners take back NAIC recommendations to their states as models for legislative action.

The NAIC has had considerable influence for more than a century, especially in determining the forms required for reports and financial statements of insurance companies.

**Separation of Accounting Procedures**
A change in general accounting procedures during the late 1920s and early 1930s did not affect insurance accounting because of legal limitations, and a separate system for the insurance business is still in effect.

The reorientation in general accounting practices was aimed at providing information for investor decision making rather than presenting figures for management and creditors. Under the new general accounting system, a uniform income concept became more important than valuation. Relevant financial information and explanation of how accounting practices were applied led to increased use of footnotes.

Insurance accounting, under statutory requirements, did not change to the new system. It continued the use of the balance sheet formula to emphasize the prime importance of solvency, with income measurement a secondary consideration.

**Solvency and Regulation**
Without solvency there is no point in other regulation; that is the principal purpose of state requirements for maintenance of minimum reserves, capital, and surplus in insurance operations. Statutes vary from state to state, but in addition to solvency they tend to stress equitable premium rates, fair treatment of policyholders, and uniform systems of financial reporting.

It is a tribute to insurers that they were not tarred by the accounting scandals rocking other industries at the start of the 21st Century. The Enron debacle, the Madoff scandal, and similar activities involving other companies and their auditors spawned a crisis of confidence among investors regarding the quality of financial reporting.

The industry also weathered the Financial Crisis of 2008. The resulting Dodd-Frank legislation created the Federal Insurance Office (FIO), which was established under Title V of the federal Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010 (Dodd-Frank). The FIO is housed within the U.S. Department of the Treasury and is headed by a director who is appointed by the Secretary of the Treasury. While the FIO serves an important role by providing necessary expertise and advice regarding insurance matters to the Treasury Department and other federal agencies, it is not a regulatory agency and its authorities do not displace the proven state insurance regulatory system.

The NAIC coordinates closely with the FIO to serve as an information resource for the federal government and to engage in international discussions in conjunction with U.S. insurance regulators.

Standard provisions to be incorporated in policies are set by most states, along with requirements for the insurance department to review and approve policy forms. Agents, salesmen, and brokers must be licensed by the state insurance department before soliciting insurance business. In most states insurance companies may not be organized without authorization by the insurance department.

Investments of insurance companies are restricted to certain kinds of assets. Methods of valuation of securities and other assets are prescribed, and items not to be reported as admitted assets in annual statements filed with insurance departments are defined.

General ledgers of most life insurance companies are maintained on a cash basis while the statutory financial statements are prepared on a modified accrual basis. Adjustments necessary for converting the balances are usually recorded on working papers rather than on the books.

Assets recorded on the books, such as cash, mortgage loans, stocks and bonds, furniture and fixtures, are referred to as "ledger assets." Furniture and fixtures, however, are non-admitted assets for the statutory statement and therefore are not shown on the balance sheet.

Assets not recorded on the books, or "non-ledger assets," include deferred and uncollected premiums, investment income due and accrued, and adjustments such as those for unrealized depreciation from cost to market values.

There are also "ledger liabilities," like those arising directly from cash transactions such as payroll deductions, and "non-ledger liabilities" not arising as a direct result of cash transactions, such as policy reserves and claims liabilities.

A life insurance company generally conducts business on a cash basis. The annual statements filed with the state authority require details of income and expense items on a cash basis, and only the totals are adjusted to an accrual basis. The accounts on the income and disbursement pages of the annual statement for state regulatory authorities do not reflect all transactions occurring during the period. Thus the trial balance is incomplete as compared to that obtained under general accounting procedure rules.

The reserve for insurance contracts, normally the largest liability of an insurance company, usually appears on a subsidiary record rather than on the general ledger. The policy reserve file is not part of the bookkeeping system and must be inventoried separately. Records of claims and their disposition are kept in claim registers, which auditors use for verifying pending or disputed claims. This information is also necessary for determining the financial position of a company.

An insurance company's profitability is usually gauged by the combined ratio and the operating ratio. The combined ratio is the sum of the following:

> Loss ratio--total of incurred losses and loss adjustment expenses expressed as a percentage of earned premiums

> Expense ratio--total of underwriting expenses in relation to written premiums

The sum of these two ratios, when applied to a company's overall results, the combined ratio is used in both insurance and reinsurance. A combined ratio below 100 percent is indicative of an underwriting profit.

The ratio of investment income to earned premiums subtracted from the combined ratio gives the operating ratio. An operating ratio of 100 per cent or more may be an indication of a declining financial position for the company. An auditor will consider the relationship of the figure to that for other industry ratios and the economic conditions in the industry generally.

**Use of Computers**

Naturally the immense amount of detail required for insurance company records has brought about the widespread use of electronic data processing in the industry. Also computer programs have been produced to facilitate reconciling the various kinds of financial reports required. As with other large-scale computer users, control risks may be involved.

**Federal Regulations**

The McCarran-Ferguson Act of 1945 leaving insurance control with the states did not deny the federal government's basic right of regulation in that field. Its main thrust was to give exemption from anti-trust laws as a practical recognition of operative needs for insurance companies.

Insurance firms making public offerings of stocks have to register them under the Securities Act of 1933 and comply with reporting requirements of the Securities and Exchange Commission, although they may be exempt from SEC insider trading or proxy solicitation rules. If they have formed holding companies, these are not insurance companies and are not exempt from SEC regulations. Insurance personnel involved in financial planning and sale of securities must be licensed by the SEC.

Failures of some large insurance companies during the 1980s and 1990s brought increased attention to regulation of the industry. The possibility of federal intervention has been mentioned by congressional leaders. An arrangement along the lines of the Federal Deposit Insurance Corporation for the banking industry has been suggested to protect individual policyholders when state safeguards fail in case of insurance bankruptcies.

The emergence of multi-national organizations and of international expansion for the insurance industry also opens questions of national regulation not only in this but in other countries where American firms will be operating.

**RECAP**

Social insurance was slow to gain acceptance in the United States because the idea of unlimited opportunities available on the frontier lingered into the twentieth century. Workers compensation was the earliest form of social insurance adopted in this country. The disaster of the Depression years modified the traditional attitude of self-sufficiency and resulted in the adoption of the Social Security system.

This massive annuity program for workers 65 and over, financed by taxes deducted from payrolls, is now basic to the American social system. In 1965 the Medicare program was added to help pay hospital and doctor bills of those covered under Social Security. Payroll taxes collected for these programs are held in trust funds invested in federal securities.

For people below the poverty line and not eligible for Medicare, the Medicaid program is administered and financed in cooperation with the states.

Medicare Part A provides hospital care and Medicare Part B pays for doctor bills and outpatient treatment. In each case Medicare pays 80 per cent of the approved charge and the patient is responsible for a co-payment of 20 per cent. There is an annual deductible of $652 for Part A and $100 for Part B, along with various other charges which may not be covered. To take care of these out-of-pocket expenses for the elderly on Medicare, supplemental policies offered by private carriers have developed into a major insurance specialty. They are known as Medigap policies.

To avoid overlapping policies and selling of unnecessary Medigap products which were reported to be victimizing some Medicare recipients, a regulatory program has limited the number and standardized the provisions of Medicare supplement policies.

The plan was mandated by an act of Congress. Detailed provisions were drawn up by the National Association of Insurance Commissioners and presented to individual states for adoption. All states have taken part in the standardization plan, although not all of the ten approved policies are available in all states or from all insurers.

Another change in Medicare regulations has been the establishment of a new fee schedule for doctors designed to slow the increase in medical costs. General practitioners are allowed more fee increases in the schedule than specialists.

Regulation of private insurers traditionally has been in the hands of state governments in this country. When the Supreme Court held that insurance was subject to federal regulation as interstate commerce, Congress passed the McCarran-Ferguson Act of 1945 to exempt insurance companies from antitrust legislation. It did not deny the basic right of the federal government to regulate insurance, but in effect left the state systems of regulation in place.

The National Association of Insurance Commissioners composed of the heads of all state insurance regulatory bodies, recommends interaction with governments on the national level and model statutes for state legislatures as needed to keep up with developments in the insurance industry.

Because statutory regulations were already on the books for state supervision of insurance companies, the change in generally accepted accounting principles to stress investment values during the late 1920s and early 1930s did not affect state forms for insurance company accounting. These continue to emphasize solvency, since that is the prime purpose of state regulation.

The possibility of federal intervention is discussed with every failure or scandal involving an insurance company. An arrangement similar to the Federal Deposit Insurance Corporation for banks has been mentioned as a possibility for assuring solvency in the insurance industry. Prospects of overseas operation by U.S. insurance companies in the future also indicate the possibility of increased intervention.

# Chapter 8 Ethics and the Professional

**For a society to function, rules are necessary.** Without rules and enforcement, there can only be anarchy. Ideally, the values basic to a civilized society are handed down to individuals through customs. These are rules of behavior that over generations have been found to help make it possible for people to live together peacefully. Observing these rules is largely a result of family training and peer pressure.

**Ethics and the Law**

There are always individuals who through ignorance, lack of training, or sheer perversity will not follow the rules. Penalties for rule-breakers make up the basic legal system of a society, backing up customs with force. Every civilized society is founded on law, and none has ever survived without it.

Ethics goes further than law in determining everyday behavior. Law cannot cover every aspect of human relationships. Personal ethics, or individual morality, has been called "what one does when nobody is looking." Law, on the other hand, sets standards for behavior in situations involving other people, and backs those standards with the power invested in law enforcement.

The subject of ethics has been prevalent in the insurance industry since the early days of insurance. In Europe, regulation was found to be a means of enforced ethics within the industry.

**Rise of Regulation**

In America, the original pattern of expansion filled legitimate needs. The insurance industry, as well as of other forms of business, grew eventually into a relentless drive for more and more success.

The results of this uncontrolled expansion and unethical practices brought on a demand for regulation. In the insurance business, state laws and licensing practices gradually developed to set required standards for companies and agents.

At the beginning of the 19th century there were only five million people in the United States, 90 percent of them farmers. There were only six cities in the country with a population of more than 8,000.

The growing cities produced an increasingly complex society in 19th century America. Individuals working for wages in a cash economy could no longer live the self-sufficient lives of their rural ancestors. In this setting, insurance rapidly became a recognized necessity for the protection of families and property.

Early insurance companies had waited for customers to come to them. As time went on and more insurers competed for business. It became the practice to advertise and send out agents in an aggressive effort at expansion. Many of these agents had little training or understanding of the principles involved in the policies they were selling.

Insurance stock companies were organized to take advantage of the growing market, and unregulated expansion continued. From 1830 to 1850, insurance in force increased by more than 3,000 per cent. After the Civil War, the growth rate of the industry was even faster. The amount of insurance in force increased at 50 per cent a year, reaching a total of two billion dollars by the end of the 1860s.

The Civil War brought unprecedented demand for manufactured goods. After the war American enterprise continued at a fast pace. New industries sprang up. Railroads crossed the continent. Cables crossed the oceans. Coal, copper, iron mines fed the factories. America was on its way to becoming the industrial colossus of the world.

**Standards Decline**

In the excitement, attitudes changed. Business and political life were no longer governed by the ethical standards once taken for granted. Tax and other scandals rocked Washington during the Grant administration. Business was drawn into wildcat schemes, stock-watering, and embezzlement.

Insurance executives and agents concentrated on achieving personal power and prestige through business

success. There were exaggerated advertising claims, carelessly written risks, and recklessly raised commissions.

**Ethics Made Into Laws**

The Massachusetts legislature in 1858 was the first to pass a law making a version of Wright's legal reserve principle a requirement for insurers. A state insurance department was created to enforce the new law and Elizur Wright became its head.

As the western part of the country was settled, the insurance industry again expanded its horizons. New companies grew up to offer insurance in the growing western cities as transportation and manufacturing facilities followed the trails blazed by the pioneers.

People moved about more, and travel restrictions were removed from insurance policies. Prudential pioneered insurance for low-income groups and it became widely accepted. By the end of the 19th century, the total of insurance in force in the United States had risen to seven and a half billion dollars.
Rapid growth again led to difficulties. Since insurance companies were the custodians of much of the nation's wealth, attention focused on them as a new "muckraking" phase of attacks on questionable business practices began shortly after the turn of the century. There was a renewed public demand for investigation of the insurance industry.

The Armstrong Investigating Committee in 1905, with Charles Evans Hughes as its chief counsel, turned its attention to insurance practices in New York. Its recommendations, backed by responsible insurance companies, resulted in the adoption of the New York Insurance Code in 1906. State supervision of insurance practices was tightened by this code, and eventually public confidence in the insurance industry was restored. Throughout the 20$^{th}$ century insurance regulation has grown.

The National Association of Insurance Commissioners (NAIC), a group made up of insurance officials from all states, has drafted model legislation which has been widely adopted by state legislatures.

The unfair trade practices act recommended by the NAIC defines unfair claims settlements, false advertising, defamation, and unfair discrimination and prohibits all these practices. This NAIC model has been adopted by nearly every state.

The resulting laws give state insurance commissioners the power to investigate when such practices are suspected and to levy fines and suspend or revoke licenses when violations are found. Marketing and disclosure standards for life insurance agents also are recommended by the NAIC. These make deceptive practices designed to mislead clients not only unethical but also illegal.

Any statement misrepresenting the benefits or coverage offered by a policy is a deceptive practice which can lead to the loss of an agent's license. Implying that future dividends provided by a participating policy will be enough to take care of premium payments would be such a misrepresentation. So would an implication that future policy dividends are guaranteed.

To tell a prospect that certain benefits in a policy being offered cannot be found in any other policy, or that an offer must be taken at once or the opportunity will be lost, would be considered unacceptable tactics. Any misleading use of figures as to cost comparisons or other significant policy features would come under the guidelines. So would statements defamatory to competing agents or insurers.

Legitimate agents recognize such actions as unethical.
They also have been made illegal in states that have adopted the NAIC recommendations. There are other prohibitions, such as offering a rebate to make a sale, or persuading a client to drop a policy just for the sake of selling a replacement that will be discussed later in detail.

While an ethical agent would not knowingly violate these guidelines, it is necessary for any insurance professional to be aware of the particular legal provisions in effect in the state with jurisdiction. The laws are to be followed first, supplemented by one's own ethical standards.

**Licensing**

Insurers must be licensed by a state to issue policies there. A state's guarantee fund usually covers only

insurers authorized to do business in that state. An agent representing an unauthorized company may be held personally liable for losses on a contract placed with an unauthorized insurer. The agent needs to be sure the company being represented is authorized to do business in that state.

It is also important for both the agent and the company office to be aware that laws can change. Actions of the state legislature and regulations issued by the state insurance commission both can vary with time and the pressure of public opinion.

Court decisions in insurance cases can make a change in liability affecting those in the industry. The legal system in this country is not static, but fluid. Company officials need to keep abreast of such developments and let their agents in the field know about them.

**Court Decisions**

Suits to recover damages in cases of disputes over insurance coverage are increasingly frequent. The growing tendency to consider insurance practitioners as professional people carries with it increased legal responsibility.

Court decisions in many cases do not take into account any responsibility on the part of the insurance purchaser to be aware of policy provisions, even of easy-to-read policies. The outcome in many liability suits has made the agent or insurance company responsible for providing adequate coverage.

In a Louisiana case a plaintiff, the operator of a Laundromat in a leased building, asked his insurance agent to get as much property damage liability for him as possible. The agent told him $100,000 was the maximum coverage obtainable, and the plaintiff told the agent to get that amount. Through an error, the policy was written for only $10,000. A boiler explosion caused $18,500 in damages at the Laundromat, and the plaintiff sued to recover the $8,500 that was not covered by the $10,000 policy.

The court appeared to place no responsibility on the owner for reading the policy, the declarations page, or the bill for the premium on the $10,000 coverage. The decision was that the insured was justified in believing that the agent had obtained the limit of liability they had discussed. The resulting point of case law is that an insurance provider cannot count on having any responsibility placed on the insured to analyze the coverage provided.

The issue of professional responsibility on the part of insurance agents and agencies is playing an increasingly important part in court cases. In a Georgia decision involving business interruption policies, an insurance agency had been provided with a client's books to use in determining what coverage limit was needed. The agency used the gross profits figure rather than gross earnings to determine the coverage needs, leaving the client underinsured.

**Professional Responsibility**

The plaintiff's argument in the court case was that the insurance agency had held itself out as an expert in the field with the needed qualifications to examine the books and determine coverage limits. The agency agreement with the client was to maintain adequate business interruption insurance based on yearly audits, and this agreement, the court held, was violated.

Such court decisions set the precedent of requiring a high standard of competence on the part of insurance professionals. Both agents and agencies need to be aware of this situation.

In addition to staying well informed and exercising due care, the responsible insurance practitioner can have professional representation available for claims protection by carrying Errors and Omissions (E & O) insurance. The E & O carrier will investigate claims situations and provide legal representation if necessary.

In the case of claims, the insurance professional needs to be prepared to deal with the claimant in a calm and competent way without overstepping limits on giving legal advice or otherwise prejudicing the case. Quick adjustment and settlement procedures are desirable in case of claims to uphold the reputation of the insurance provider, but it is important to have all the facts at hand before action is taken.

In dealing with a claimant, the insurance provider needs to remember not to give advice or promise to get the claim paid. It is also important, however, not to deny a claim without positive knowledge that it is invalid.

Also, a claim should never be paid without certain authority. Any of these actions can create legal liability.

It is helpful in avoiding legal difficulties for the agent to maintain friendly relations with clients and establish a reputation for being trustworthy over the long term. A personal relationship of trust and confidence between agent and client may help avoid lawsuits and make settlements easier.

**Ethics Commissions**
In addition to court cases, changes in the law can be brought about by an increasingly important agent, the ethics commission. Under pressure from activists, consumer protection groups and others, Ethics Commissions have been set up in state and national legislative bodies as well as in local government agencies.

Ethics Commissions tend to focus on lobbying, gifts to officials, conflicts of interest, and election procedures. They also, however, can consider other areas of public concern and produce legislation in response to consumer complaints.

An ethics commission can hold public hearings. It can determine what legislation needs to be passed in order to prevent abuses. It can investigate whether behavior of a public official has violated existing laws.

Congressional committees in both the Senate and the House have been conducting investigations into insurance cases with a view to possible federal legislation supplementing state level regulation of the industry. A Senate committee probe has centered on offshore insurers and reinsurers which are not subject to state regulation.

One reinsurer listed as its primary assets $22 million in "treasury bills" claimed to have been issued by a Texas Indian tribe. Senate investigators believed this group to be fictitious. One of the tribe officials known as "Wise Otter" was thought to be a British subject.

The House investigation that followed the failures of large domestic insurance companies has focused on the possibility of setting up a federal support mechanism similar to the banking industry's Federal Deposit Insurance Corporation in order to protect policy holders beyond state agencies' limits.
It is important for insurance professionals to keep abreast of such legal developments affecting the industry and its traditional standards.

**SEC Requirements**
Financial planning, a relatively new field for insurance providers, requires some specialized knowledge relating to securities and investment regulations. The Securities and Exchange Commission through the Investment Advisers Act sets high ethical standards for professional providers of investment advice.

Any transaction or business practice intended to deceive a client or prospective client is strictly forbidden under the act. The agent acting as a securities representative is legally required to act with due diligence, meaning that documented financial information must be furnished on companies whose stocks or bonds are being sold.

**Guidelines**
In contrast to due diligence for securities salesmen, the standard established in court cases for agents only involved in selling insurance is due care. The client is given financial information on request, but the state insurance department is the agency responsible for requiring reports from companies authorized to do business in that state. The agent's legal obligation is to sell policies of insurance companies licensed in that state and not to sell policies of companies the agent knows to be insolvent.

**Claims Defense**
An agency can establish a back-up line of defense against claims arising from insurance company insolvency. This can be done by showing proof that the agency has maintained a system for tracking financial conditions in the industry through figures from the various reporting agencies and by other means available.

It is important for the insurance agent to know the specific do's and do not's that constitute ethical behavior. Specifics that will be discussed are advertising, commissions (rebates), agent conduct, clients' files,

illustrations and underwriting.

**Agent Compliance**

**Advertising**
When the agent advertises, he/she is making the product known to the public at large. There are many different ways to advertise. The following are the major methods, of advertising.

- Printed and/or published materials.
- Newspaper, radio, television, computers, billboards.
- Ads, circulars, leaflets, descriptive literature.
- Business cards, business brochures, prepared sales talks.
- Telephone solicitations.
- Any material used to sell, modify, update or retain a policy of insurance.

Agents wishing to advertise must-obtain approval from their respective insurance company. All advertisements for life, accident, and health insurance must include and identify the insurance company the agent represent.

Advertisement that would not require prior insurance company approval would be one in which the only information given is the agent's name, address, telephone number, and description of the services being offered. Agency history and a simple statement of products offered, such as life, health, and/or annuities would also apply. There must be no reference made to specific policies, benefits or cost.

**Requirements**

**The agent must do the following in all advertising**:

- Make clear that insurance is the subject of the solicitation; clearly identify the type of insurance being sold, and the full name of the insurer.
- Include all limitations and exclusions affecting the payment of benefits or cost of a policy, as well as disclose any charges or penalties, such as administrative fees, and surrender charges contained in a life or annuity policy, or withdrawals made during the duration of the contract years.
- If a policy offers optional benefits or riders, disclose that each optional benefit or rider is available for an additional cost.
- For a life insurance policy with accelerated death benefits, clearly disclose the conditions, care or confinement which will initiate any acceleration of payment of the death benefit and/or other values under the life policy.
- If a policy includes a payment endorsement, disclose that fact.

**Proscriptions**

**The agent MUST NOT do the following in any advertising**:

- Be deceptive or misleading by overall impression or explicit information.
- Refer to considerations paid on an individual policy or annuity, including policy fees.
- Use terms such as "Financial Planner", "Investment Advisor", "Financial Consultant", or "Financial Services" in such a way as to imply the engagement in an advisory business in which compensation is unrelated to insurance sales, unless this is actually the case.
- Use a service mark, trade name or group designation without disclosing the name of the actual insurer, if specific coverages benefits or costs are described.
- Make unfair or incomplete comparisons of policies.
- Disparage competitors, their products, their policies, their services, business or marketing methods.
- Make untrue or misleading statements with respect to another company's insured assets, financial standing or relative position in the insurance business.
- Imply group coverage, certificate or enrollment when the policy offered is actually an individual policy.
- State that the policy is a limited offer and the applicants will receive advantages by accepting

the offer, and that such advantages will not be available at a later date, if this is not the fact.

- Advertise a free gift, bonus, or anything of value outside of -the policy contract, which is an inducement to buy and considered rebating.
- Advertise for life, health, accident or annuities, use the existence of the GUARANTEE ASSOCIATION as an inducement to buy.
- Use misleading words or symbols or imply the material is being sent by a government entity.
- Use the phrase "low cost" without providing disclosures and the caveats associated with the particular plan.

Advertising can be one of the best career enhancing tools, when utilized effectively, legally and ethically.

**Commissions**

Commissions are the direct result of work performed by the agent with a new or existing policy owner. The agent's compensation is paid direct from the respective insurance company for the type of product and services recommended and are willing to provide. In addition to the initial commission, most insurance companies provide "renewal commissions", as an inducement to continue servicing the existing policy owners.

**The Concept**

This concept, initiated many decades ago, was intended to accomplish two primary objectives:

1. Compensate the agent for future servicing needs the policy owner will require -- such as beneficiary changes, bank draft changes, endorsements, etc.
2. Provide the agent with an opportunity to perform periodic reevaluations of the policy owners' needs, thereby resulting in additional sales opportunities.

The agent, as a licensed insurance person, shall not directly or indirectly rebate or attempt to rebate all or any part of a commission for insurance. Rebating is illegal in most states, and is strictly prohibited. It can be punishable by fine, cancellation of contract with insurance company, and loss of license, or a combination of all three. Rebating can be described as offering any type of inducement other than what is contained in the policy itself, in exchange for purchase of insurance. Examples include, but are not limited to the following:

- Any verbal or written agreement for the agent to pay any part of a policy owner's premium.
- Any payment, allowance, or gifts of any kind offered or given as an inducement to purchase insurance.
- Any paid employment or contract for services.
- Returning any part of the premium to the policy owner.
- Offering any special advantage regarding the dividend, interest, or other policy benefits to the policy owner which are not specified in the policy.
- Offering to buy, sell, or give any type of security (stocks, bonds, etc.) or property, or any dividends or income from securities or property, to the policy owners' benefit.
- Giving anything of value to the policy owner in return for buying an insurance product.

**Rebating**

Rebating, or the attempt to rebate, is an offense not only under the Code of Ethics, but also under state insurance laws. There may be borderline situations in which it is difficult to determine whether rebating has taken place.

**Borderline Situations**

It is fairly common practice, as an example, for an insurance agent to entertain policy owners or prospective purchasers with a meal and perhaps give a nominal or token gift such as a policy wallet. Such things are considered to be normal business practice, and not in the nature of a rebate. However, should the agent contemplate anything more than such token gestures of appreciation, then the greatest caution and good judgment must be exercised. Excessive benefits or gifts conferred upon policy owners or prospective purchasers, will at the very least be considered in bad taste, and at the worst, depending on all the circumstances, may expose the licensee to a charge of rebating. In no circumstances should a gift of

anything of value be given as an inducement to purchase insurance.

The rules for rebating do not apply to splitting of business with another licensed insurance agent. Joint case work is very common throughout the industry, and splitting of commissions is normal business practice. This practice does not apply to equity and variable life products, since they are sold under the rules and guidelines of the Securities Exchange Commission.

**Agent's Conduct**
As an insurance professional, the agent becomes part of the insurance industry's public relations arm. The agent meets the public every day, and the manner and conduct exhibited leaves a lasting impression with everyone with whom that agent had contact.

A big part of professionalism is the attitude toward competition; therefore, agents should avoid criticizing other agents. Such activity is detrimental to everyone in the business. Any criticism of another company's policies should be avoided. An incomplete comparison is not only misleading and harmful to the public, it can also result in license revocation for the guilty party. Respect for competitors helps to keep policy owners satisfied.

The agent is under an obligation to make accurate and complete disclosure of all information which policy owners or prospective purchasers should have, in order for them to make a decision in their best interest.

Representing the Insurance Product
The agent is called upon daily to make many statements and representations, oral and written, upon which policy owners and prospects are entitled to rely. Such statements and representations must not only be accurate, but must also be sufficiently complete to prevent any wrong or misleading conclusions from being made by policy owners or prospects. It is just as wrong for a life underwriter to omit giving essential information, such as, failing to correct a mistaken impression which is known to exist, as it is to give inaccurate or misleading information. Representing insurance products as exclusively "retirement plans", "college education plans" or "savings plans", without noting that the life insurance is primary and the cash value features are secondary, can result in serious charges of misrepresentation of insurance products. Use of the word "deposit" versus "premium" can have a like effect.

**Deceptive Practices**
**As they pertain to the insurance industry deceptive practices have countless examples, a few of which are:**

- Passing off the agent's own goods or services as someone else's.
- Misrepresenting the benefits, uses, or characteristics of the product.
- Making disparaging remarks pertaining to someone else's products, services, company, by making false or misleading representations.
- Advertising the product or rates while intending not to sell them as advertised.
- Misrepresenting the agent's authority as a sales person, representative, or agent to negotiate the final terms of the contract with the policy owner.
- Offering, in connection with an insurance purchase, participation in a "multi-level distributorship" under which payments are conditioned on the recruitment of additional sales people rather than the proceeds from the product sales.
- Using the terms "corporation" or "incorporated" or their abbreviations in the name of a non-incorporated business.
- Failing to disclose information during a transaction with the intent of inducing a prospect or policy owner to do something he or she would not do otherwise.
- The law allows courts to award an insured triple damages, court costs, and attorney fees, for deceptive insurance trade practices.
- Insurance is not only a complex product, it is an extremely complex industry. The insurance agent must be very careful not to mislead the consumer regarding any aspect of an insurance transaction.
- Misrepresentations can be in the form of an oral or written statement, advertisement in any media, use of a business logo or advertising slogan, or anything else that communicates a false or misleading idea. A few examples of misrepresentation include:

- False or misleading statements about a particular policy.
- False or misleading statements about the financial condition of a respective insurance company.
- Telling a prospect or policy owner that dividends or current assumption mortality charges are guaranteed.
- Identifying a term life policy by a name that implies cash value accumulation, or vice-versa.
- Indicating that premiums on a policy are payable for a shorter time period, when the premiums may be payable for life.
- Indicating that the agent represents several insurance companies, when in fact the agent represents only one.

A high degree of ethical representation is good solid business. The agent's insurance career can provide financial gain and personal growth. Practicing as an ethical professional will bring both. The agent's actions will gain the respect of the policy owners as well as that of the insurance carriers. The agent's reputation will be significantly enhanced, and people in the community will want to do business with that agent.

**Documenting Clients' Files**
Documenting the client files involves keeping track of the actions taken in dealing with the policy owner. A properly documented file should contain complete and accurate answers to all pertinent questions. This allows the agent to properly assess the need for insurance and substantiates the reason for the sale.

**Paper Trail**
After the fact-finding meeting, the agent should send a discovery agreement to the prospective policy owner summarizing the initial meeting and outlining the agent's understanding of the policy owner's short-term and long-term financial goals. This document should also contain information about the policy owner's salary and expenses, and the amount of money in savings accounts and investments. It should also reiterate the amount of insurance in force and the amount of money the policy owner would be able to allocate for insurance premiums. In addition to this, the discovery agreement should thank the policy owner for the chance to work with them, and confirm the date of the agent's next meeting.

The agent should always keep on file a proper ledger illustration. This should be an approved insurance company ledger, a sales proposal/idea that contains the following elements:

1. Insurance company name.
2. A full dividend/interest rate crediting disclaimer.
3. A clear description of the product.
4. The agent's name and illustration date.
5. Guaranteed values.
6. A page containing full explanation of any assumptions or special instructions.

**Data Note and Log**
Effective case notes should also be kept in the policy owner's file. These should list the date and time of contact with the policy owner and concise summaries of all interactions. It is also recommended that the agent document the level of service provided to the policy owner.

An effective log of all telephone calls should be kept, listing the date, time, reason, and follow-up action of all telephone conversations with the policy owner. The agent should also note all unsuccessful calls to the policy owner in order to verify the attempts to provide proper service, thus, once again, documenting the level of service provided.

A delivery letter should be sent to each policy owner with a copy kept in their file. This letter would reinforce the information already discussed, such as the reason for purchasing the insurance, and the type of plan as well as the face amount of coverage. The agent should reiterate the amount and duration of premium payments, as well as the premium payment method. The agent should also restate the impact on policy values as it relates to borrowing, partial surrenders, advanced premiums, interest requirements, dividend usage, and if appropriate, interest or dividend crediting performance.

Many companies provide a delivery receipt with the policy that must be signed by the policy owner upon

delivery. If the company does not, it is recommended that the agent prepare such a document to be signed upon delivery to the policy owners. It should list the date the policy was received by the agent, the policy number, and the insurance company's name. It should also contain the owner's signature and the date they signed for delivery of the policy. All of this should be kept in the policy owner's file.

**Illustrations**

Illustrations have been used extensively in the insurance industry for several decades to help secure sales. In the past, they were obtained from the respective insurance company, and were fairly bland and standardized for many years. They were straight forward and represented a close approximation of actual future performance.

**Changes Cause Problems**

Beginning in the early 1980's, a radical change began, primarily due to three events occurring simultaneously:

1. A significant reduction in mortality charges, due to advancement in medical technology.
2. Significant advancement in electronic technology -- also known as low cost personal computers.
3. A significant economic change resulting in double-digit market interest rates.

These three events, coupled with consumer demand, helped produce a product called Universal Life -- an unbundled, interest sensitive, whole life policy with a high degree of flexibility.

Insurance was viewed more as an investment product consisting of "mortality" and "side funds". Illustrations began to change and use historically high double-digit interest rates as the basis for projected values. As interest rates began to fall in the late 80's, projected values did not hold up to reality. Many policy owners received notices that premiums would have to be increased or death benefits reduced to keep policies in force. Policy owners became angry, and many accused agents and companies of unethical behavior.

It cannot be overemphasized that illustrations are mere projections based on current interest rates, current mortality charges and other expenses. These conditions are not contractual obligations. Agents who have competed on the basis of high interest returns will produce projections that are unrealistic. This blatant misuse of illustrations has led to policy owner confusion and dissatisfaction. Agents, companies, and the insurance industry have suffered tarnished reputations.

The results have been fierce disciplinary actions backed by a series of heavy fines on some insurance companies by state regulators. Some examples of illustration abuse are as follows:

- Falling prey to the allure of high interest returns.
- Use of "assumed" interest rates in competitive situations.
- The sales technique of "Vanishing Premiums".
- Heavy emphasis on accumulated values verses death benefits.
- Poor emphasis of contractual guaranteed values and the potential problems that could exist in the future.

Remember, the policy owner does not necessarily see the illustrations as hypothetical. Policy owner dissatisfaction has resulted in increased demands by state regulators for heavy regulations regarding illustrations. Some insurance departments are considering the elimination of current assumptions, and only allowing illustrations based on guaranteed values. The parameters of an illustration under these proposals would be strictly monitored. They have also suggested that disclosure of past performance will be all that is permissible.

**Understanding the Hypothetical**

Many companies provide guidelines regarding interest rates to be used in product illustrations. The agent is advised to stay within the company guidelines to avoid policy owner dissatisfaction. Policy owners should be aware that current illustrations are a snap shot of how a policy might work if the current rates remained unchanged. To help with this awareness, illustrations should have three distinct columns:

1. Guaranteed Values.
2. Current Return Values.
3. Current Return Minus 1%.

This type of diligence will reward the agent with greater policy owner understanding of how interest rates and dividend scales can affect cash values and premiums.

Illustrations are rarely valid for policy comparisons. They are designed to show how a particular product of a particular company works. There are too many inconsistent variables from one company to another to allow for valid comparison. Policy selection should be made on knowledge of the product and analysis of assumptions underlying each policy. Policy provisions, company financial condition, and quality of service are valid considerations. Illustrations only, can be a dangerous criterion for policy selection without additional considerations.

**Transparency and Self-Policing**

The vanishing premium concept has been particularly damaging to the public perception of insurance industry ethics. This concept is based on the premise that premiums may be discontinued after a certain number of years through the use of cash value or dividends. It was used as a marketing tool extensively in the 1980's. Projections of vanishing premiums (typically in six to eight years) were based on high interest rates in effect at that time. Many policy owners did not understand that a continuation of high interest rate was necessary to fulfill illustrated projections. When interest rates fell, policy owners charged that no one explained the fact that the illustrated "vanish" was not guaranteed. This disappointment can be avoided with proper disclosure of illustrated concepts and the effect of changing interest rates. Good ethics and business practice dictates that illustrations show both guaranteed and non-guaranteed values with the difference clearly explained to the policy owner. Any illustrations showing non-guaranteed values may be incorrect after the first year. The agent should be thoroughly informed about "assumptions" and "hypothetical" and the effect of fluctuating interest rates and mortality charges. This additional risk should be communicated to the policy owner in written as well as verbal form.

There are many types of new generation policies which require due care and full disclosure. These include Blended Policies (permanent and term), Adjustable Policies, First-to-Die Policies, and Second-to-Die Policies. When two or more lives are insured under the same contract, particular care should be taken to explain to the policy owners that the death benefit is paid on the death of only one of the insureds.

Falling interest can create a climate where actual performance falls short of illustrated projections. Very often, policy owners do not understand the difference between hypothetical projections and contractual guarantees. This can lead to policy owner dissatisfaction, complaints and potential litigation. Increased policy owner complaints lead to adverse insurance department rulings, state regulations, fines and lawsuits against companies and agents. This affects the public perception of ethical conduct of the entire insurance industry. The solution lies in ethical business practices, particularly concerning policy owner understanding of illustrations. Self-policing through education, discretion and common sense will lead to field practices of a high ethical standard. It is important to remember that the policy owner will retain that information they see as most beneficial. As a professional community, our watch words are, tell the policy owner the truth.

Replacement of a contract of life insurance means any transaction which includes a:

- Rescinded, lapsed or surrendered policy.
- Charge to paid-up insurance, continued as extended term insurance or placed under automatic premium loan.
- Change in any manner to effect a reduction of benefits.
- Change so that cash values in excess of 50% are released.
- Policy subjected to substantial borrowing of cash value, but does not include the purchase of an additional life insurance contract.

The agent should not, when it could be detrimental to the interest of the policy owner, replace an existing contract of life, health, disability and annuity contracts with a new insurance contract. Every reasonable effort should be made to maintain the existing contract in force.

Where it appears that, due to a change in circumstances, an existing contract of insurance should be amended or changed; the agent should ensure that the policy owner is fully informed of any values, credits, or privileges in the existing contract which can be transferred to an amended or changed contract of insurance.

**Service**
One study indicated that the average insured purchases insurance seven times during their lifetime - from six different agents. Is part of the reason because of poor or lackluster service?

The insurance industry employs and contracts nearly two million people. It is quite evident that insurance is an intricate and essential service in our society. It is a field upon which our society depends more and more for financial protection. Life and health insurance purchases continue to increase each year. Property and casualty insurance is a part of every mortgage contract, auto ownership, and business coverage. Life insurance in force at the end of 1993 was nearly $11 trillion. On a daily basis a large group of people will die, enter retirement, experience a cash emergency, or have a physical asset damaged or destroyed. This is the real world- it affects everyone! These are critical times. The agent's insurance company, the agent, and the policy sold, stand between the client and financial disaster.

**Value Added**
The insurance agent must be the "value added" benefit for the insured as well as the insurance company. In the decade of high tech mega information highway, The agent has to be the interpreting guide and the analyst for the general public to solve financial problems with an insurance purchase. The agent must also become the motivator, leading a prospect to action.

People like to do business with people they trust. Trust is built on ethical behavior. When potential prospects and existing policy owners find an agent with high ethical standards, they tend to do more business with the agent -- therefore becoming a client. In perhaps no other industry is the element of trust more important.

Charging fees for service is common practice in most occupational groups; however, Texas has an exception for insurance agents. Group I licensed agents are not allowed to charge fees for service unless they are properly licensed as a Certified Insurance Counselor (CIC). Property and casualty licensed agents are also allowed to charge fees for certain services.

**Service Essentials**
The service to a policy owner/client is not only qualitative, but also quantitative. Periodic contact is essential, but can take various forms:

- Daily phone contact with the same policy owner would not only be extremely expensive and cumbersome, but also non productive and obnoxious. Most policy owners tend to accept three to six months intervals as a good basis for agent contact. This could be in the form of telephone calls, letters, informative announcements, as well as birthday and Christmas cards. Many agents use Thanksgiving cards as an alternative to the more commonplace Christmas card mailing.
- Annual reviews are extremely important with many policy owners, simply because their needs change. This is particularly obvious with business clients.
- It is definitely recommended that the agent staff her/his office with people able to handle day to day service needs, such as change of beneficiary designations, bank draft changes, policy amendments or endorsements, etc. If the agent elects to refer all of these tasks to the respective insurance company home office, it would significantly reduce the "value added" benefit that serve the policy owner. It would also enhance the likelihood of future replacement from another insurance agent -- who specializes in service.

Generally speaking, policy owners want convenience and immediate response. An agent, who refers policy owner service duties directly to the insurance company, is missing tremendous future sales opportunities, alienating themselves from building the trusted relationship necessary to maintain a strong business practice, and presenting themselves in less than an exemplary fashion.

**Underwriting**
Perhaps no other area pertaining to compliance and ethics deserves as much attention as agent underwriting. When any type of claim occurs, the insurance application becomes the basis for a claim dispute, denial or acceptance. An agent, who compromises part of the underwriting process with false or

misleading information, as it pertains to the prospective insured, is creating potential wealth for litigating attorneys.

**Part of the Contract**

The agent must always remember that an underwritten application becomes part of any insurance contract. It is critical that all questions be answered completely and honestly. Too often it is tempting for an agent to "trim" ten or twenty pounds off a rather overweight insured or help them grow one or two inches, in order to assure a standard issue from the respective insurance company. Asking a potential policy owner to discard a lit cigarette during the application process may create non-smoker discounts, but in all likelihood would initiate a claim denial. Insurance companies have challenged fraudulent non-smoker rated policies through the court system, and won. It is also naive for the agent to believe that a two-year incontestability clause will exempt him/her or the insured from blatant, fraudulent underwriting. Insurance companies may pay a claim, but they can and do pursue legal action against the insured's estate.

The agent should make every effort to provide the insurance company with all accurate information pertaining to the prospective insured. Cover letters should be submitted with the application to provide details of unusual or extensive medical history or information; unusual business uses of insurance; foreign travel and residence; unusual financial situations; unusual beneficiary and ownership arrangements to clarify the insurable interest; unusual occupational duties; and any case discussions with an underwriter prior to the application submission.

Many insurance agents order medical examinations, attending physician statements, and financial information through third party sources, and upon receipt forward these items to the insurance company. This is not an illegal practice, but it may be against the company's practice. Since underwriting information is highly confidential, both the originals and photocopies of financial statements, attending physician statements, hospital abstracts and other confidential records that have been obtained by agency personnel require safeguarding.

**Protect Confidentiality**

To comply with state and federal privacy laws and to control and protect confidential information provided to the company by applicants, guidelines need to be followed to insure the strictest handling of these documents. Examples to follow are:

- Access to files containing confidential material must be restricted to employees who have legitimate "need to know" in order to perform their assigned duties.
- Confidential information stored in personal files, should be retained only as long as there is legitimate need.
- Some companies absolutely forbid the acquisition and retention of medical examinations, attending physician statements, hospital abstracts or other medical histories.
- It is up to the agent to know what the insurance company's practices are.

Since the application is such an integral part of the insurance contract, care should be utilized in presenting all information to the insurance company in a professional manner. One of the most consistent complaints with insurance company underwriters is illegible applications. Not only does this impair the underwriting process, but it could be grounds for significant dispute during the processing of a claim.

Generally, changes or alterations to the application must be initialed by the insured/applicant. This is specifically important in changes in plan, face amount, owner, beneficiary, medical or financial representations and dates. Some companies are more lenient and allow amendment signatures at the contract delivery.

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The National Association of Insurance Commissioners has a Model Privacy Act that requires any applicant/insured to be notified of any adverse action taken in regard to their application. This Act allows an insured the right to know the details of the personal information about themselves in the company files, and has the right to request an insurance company to amend, delete, and correct such information.

**Litmus Test**

Labeling a decision as an "ethical decision" may disguise the fact that almost every decision holds some ethical issue or impact. Perhaps a better approach would be to develop an ability to judge the ethical implications. What role do ethics play in this decision? How does one recognize an ethical situation or problem? What are the warning signs that this may be a tougher decision with deeper issues and wider impact? Here are some guidelines. Not all apply every time, but they should raise understanding and improve the decision-making process.

Do I put a monetary value on this decision? Would I make this decision differently if cost were not a factor? Am I putting a monetary value on my ethics?

Do words such as right, fairness, truth, perception, values, or principles appear in my reasoning when I am making my decision?

- Do I feel as if I need to search through a standard policies and procedures or contact a legal representative for help with my decision?
- Do questions of fair treatment arise?
- Do my personal goals or values conflict with my professional ones?
- Could this decision generate strong feelings or other controversy?
- What does my heart tell me? Do I ponder this decision on the way home?
- Do I offer myself excuses such as everybody does it, or no one will find out, or I did it for "The Company"?
- Does this decision really need to be made by someone else? Did I inherit it because someone else doesn't want to make it?
- How am I going to feel tomorrow if I do this?

If an individual faces a tough decision and feels as if some guidance is needed, sometimes there is no place else to turn. One must have an internal compass, a value system for guidance. That is why an ethical standard is important for everyone in the insurance industry.