Suitability Issues Part II

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This booklet is intended to provide you with accurate and useful information, ideas and applications. However, the information contained herein is subject to change through legislation or from industry practice.

The sample codes presented herein were accurate as of the date this publication was created. However, any changes by the respective organizations may substantially affect the information presented.

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advice.

RATINGS AND AGENTS

Agents can easily be lulled into believing that placing business with an A-rated or better company is sufficient to stay out of trouble. Unfortunately, some in the industry are of the opinion that even well-rated companies are at risk of failing. If so, your clients and their attorneys may attempt to hold you responsible.

You might be asking what you are supposed to do: After all, if regulators and rating agencies with all their resources can't predict a solvency how can an independent agent or producer be expected to know? Isn't reliance on an authoritative third-party rating agency sufficient due diligence?

History has proven that a high rating is not a guarantee of anything other than the fact that at the time the ratings occurred, a particular company is more solid than another. And, this fact can change rapidly as it did in the late 1980's when even A+ company balance sheets deteriorated within a matter of months. The decline was not just a drop in ratings; for some companies it was a drop to liquidation. Also, rating agencies, as you will soon see, have created complicated systems of classification with many qualitative and quantitative measurements. This makes a complete explanation of their criteria almost impossible and it is why virtually all rating companies include disclaimers in their analysis.

In general, a higher rating can mean a lower probability of failure compared to insurers that are not rated as well. Again, however, there are no guarantees. You can advise your clients that the company is licensed in the state to conduct business and that the company and industry-accepted rating services suggest it is in good financial standing; however, you are not a guarantor of its future financial condition.

Here is how a sample disclosure might read: “While we are pleased to provide to you and explain the industry ratings of a particular company or alternate insurers, we do not make any independent investigation of a specific company's solvency or financial stability. We do not warrant or guarantee that any insurance company will remain solvent, and we will not be liable to any insurance applicant or insured for the failure or inability of an insurance company to pay claims.”

Another misconception by agents is that the use of one rating service is sufficient to determine an insurers financial condition. In fact, you would be encouraged to consult the ratings of at least three services. If the rating of your company by all three is consistent, there is some agreement among the raters on the financial condition of your company. However, if the ratings vary widely, this might be a signal that there are factors for concern.

Company Ratings

The activities of insurance company rating agencies have become increasingly prominent with the industry's financial difficulties and any well-publicized failures of several large insurers. The ratings issued by these agencies represent their opinions of the insurers' financial conditions and their ability to meet their obligations to policy holders. Rating downgrades are watched closely and can significantly affect an insurer's ability to attract and retain business. Even the rumor of a downgrade may precipitate a run on the bank, as in the case of Mutual Benefit years ago, and seriously exacerbate an insurer's financial problems.

There is little doubt that rating organizations play a significant role in the insurance marketplace. Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization, A.M. Best, a number of new raters emerged during the 1980s.

Questions have been raised about the motivations and methods of the raters in light of the sensitivity surrounding an insurers' financial conditions and what some perceive to be a rash of arbitrary downgrades. On the one hand, insurer ratings historically have been criticized for being inflated or overly positive. On the other side, there are concerns that raters, in an effort to regain credibility, have lowered their ratings arbitrarily in reaction to declines in the bond and real estate markets and the resulting insurer failures and diminished consumer confidence.

Of particular concern to some regulators and the industry are the practices of Weiss Research and Standard & Poor's (S&P) publications of qualified solvency ratings. Both the Weiss "safety" ratings and the S&P "qualified solvency" ratings are based on a strictly quantitative analysis of financial data. While there has been a concern about inflated ratings historically, Weiss has been criticized for marketing bad news to consumers, i.e. ratings that are skewed to the negative.

S&P's qualified solvency ratings also have been criticized for utilizing a scale that appears to be lower than their claims paying ability ratings. Some have accused S&P of using the qualified solvency ratings to "extort" insurers to pay a $22,000 - $28,000 fee to obtain a higher claims paying ability rating. S&P strongly denies these allegations and believes that consumers and agents properly understand the meaning of the qualified solvency ratings.

Both S&P and Weiss contend that their quantitative ratings provide valuable, unbiased information to consumers. The influence of the rating agencies and the practices of Weiss and S&P have prompted some regulators and insurers to suggest that the states and others should limit access to their database, which is utilized by these raters. There also have been calls for regulators and the NAIC to evaluate and certify rating agencies to ensure that their methods and practices meet certain established standards. However, other regulators have questioned whether it is appropriate and practical for regulators to withhold data or regulate rating agencies.

The regulators suggest that a more appropriate regulatory role is to improve consumers' understanding of the rating process and allow them to decide how to use the information raters provide. This discussion of the rating agencies presents certain factual information relating to the structure and activities of the five most prominent rating agencies: A.M. Best, Standard & Poor's, Moody's, Duff and Phelp's and Weiss Research.

The philosophy, scope, fees, resources, process, methodology and classification scheme of each of these agencies is described below. While issues relating to certain practices of the raters are discussed, this is not an attempt to evaluate the validity of the raters' methods or practices.

Remember, an insurer failure may render you liable for losses or at least a target for expensive litigation. Therefore, it is reasonable that you should take steps to avoid this by becoming a student of insurance company ratings, regulations and benchmarks.

A.M. BEST COMPANY

The A.M. Best Company has been rating insurance companies since 1906 and its' long association with the industry is important to understanding its philosophy and approach. Its stated mission is "to perform a constructive and objective role in the insurance industry towards the prevention of insurer insolvencies ". Best views its ratings as an inducement for insurers to operate in a prudent manner and maintain strong financial health. It actively consults with and advises companies on the basis for their rating and what actions a company must take to maintain its rating or improve it.

The objective of Best's rating system is to evaluate the factors affecting the overall performance of an insurance company and to provide its opinion as to the company's relative financial strength and ability to meets its contractual obligations. Best conducts an extensive quantitative and qualitative evaluation of rated insurers based on various sources of information and knowledge of the company accumulated over a long period of time.

This knowledge is acquired through frequent contacts with company officials as well as statutory financial statements, special questionnaires and a variety of other sources. Typically, there will be meetings once a year with company management at Best's headquarters in Oldwick, New Jersey. There may be more meetings, if necessary, but Best attempts to meet at least once with a company over a two-year period, in addition to telephone contacts and correspondence.

If adverse developments occur that may affect a company's financial condition, Best will discuss the situation with management. If the company can present an effective plan to resolve the problem, Best may not immediately downgrade the company. The company's situation would continue to be monitored to ensure that the corrective action was implemented.

To obtain an alphabetical Best's rating, an insurer must have been in existence for at least five consecutive years of representative operating experience, have net premiums in excess of $1.5 million for a life/health insurer, $1.5 million in surplus for a property/casualty insurer, submit the requested financial information and pay a $500 fee.

In a recent edition of Best Insurance Reports, 811 life/health insurers and 1,513 property/casualty insurers received an alphabetical rating. An additional 530 life/health insurers and 970 property/casualty insurers received rating "not assigned" (NA) classifications which explains why they did not meet Best's eligibility requirements. Of these non-rated companies, 291 life/health insurers and 597 property/casualty insurers received a Financial Performance Index (FPI) assignment, introduced in 1990.

Insurers are required to have at least three consecutive years of representative operating experience to obtain an FPI rating. The $500 fee does not apply to companies receiving a "not assigned" rating classification or an FPI assignment. Insurers can elect to not have their rating published. If that happens, a company receives an NA-9 "Company Request" designation. In this instance, Best normally requires a minimum of two years to elapse before the company is again eligible for the assignment of a rating.

A typical Best's alphabetical rating consisted of nine categories, ranging from A+ (Superior) to C- (Fair). In the 1990's, A.M. Best announced an expansion of its alphabetical categories to fifteen ratings. They range from A++ (Superior) to F (In Liquidation). The stated purpose of this expansion was to add finer distinctions among rated companies. About the same time frame, Best also eliminated its "Contingent Rating" modifier and the rating categories of NA-7 (Below Minimum Standards) and NA- 10 (Under State Supervision). Also, a new category NA-11 (Rating Suspended) was added.

Best's analysts typically possess significant experience with respect to financial analysis of insurance companies, acquired at Best as well as in the industry. The productivity of Best's analysts also is enhanced by sophisticated computer-based analytical tools and a large amount of information accumulated on each company. In addition, A.M. Best has ongoing consulting and educational arrangements with a professional reinsurer, an accounting firm and an actuarial firm to keep its analysis informed of current developments and industry issues.

Rating Methodology: The objective of Best's rating system, as described in its literature, is "to evaluate the factors affecting the overall performance of an insurance company in order to provide our opinion as to the company's relative financial strength and ability to meet contractual obligations."

Best's ratings are based on a quantitative evaluation of a company's performance with respect to profitability, leverage and liquidity and a qualitative evaluation of its spread of risk, reinsurance program, investments, reserves and management. The quantitative evaluation analyzes an insurer's reported financial condition and operating performance for at least the previous five years against industry peer group and Best's financial norms, utilizing more than 100 financial tests and supporting data.

If a company has a relationship with an affiliate through an investment, reinsurance or pooling agreement, data is consolidated to reflect this affiliation. Best views profit as a measure of the management's competence and ability to provide insurance at competitive prices and maintain a financially strong company. Best's profitability analysis reviews the degree, trends and components of earnings over the most recent five-year period. Net investment income, federal income taxes, expenses, mortality and persistency (life companies only), reinsurance, reserving practices and methods, statement versus market value of assets, regulatory constraints and underwriting experience are evaluated with regard to their relative effect on a company's earnings and capital and surplus. Also, the stability, trend, type and diversification of premium volume are evaluated as to their impact or potential impact on an insurer's reported statutory operating results.

Best is watchful of highly leveraged companies that are exposed to a high risk of instability and adverse changes in underwriting or economic conditions. Best reviews a number of leverage measures including the ratio of premium to capital and surplus, both gross and net of reinsurance. Affiliated investments are considered in the analysis of capital and surplus which also is adjusted to reflect the adequacy and equity of policy reserves, the market value of assets and potential default risk, market value fluctuation, nonperforming assets and reinsurance quality.

For property/casualty companies, Best looks at the ratio of reinsurance premiums ceded and loss reserves to surplus to measure the companies' exposure and dependence on reinsurance. The leverage analysis evaluates the relationship of net liabilities to adjusted surplus, insurance and investment risk based capitalization and other tests which measure a company's surplus or its asset and insurance risks. Best believes that insurers' liabilities should be supported by sound, diversified and liquid investments to meet unexpected needs for cash without the untimely sale of investments or fixed assets.

Best measures an insurer's quick liquidity position -- the amount of cash and quickly convertible investments as a percentage of liabilities; "current liquidity" – the amount of cash and unaffiliated invested assets as a percentage of liabilities; and its cash flow position. The assessment of an insurer's liquidity incorporates an evaluation of the quality, market value, and diversification of assets, cash flow and asset/liability matching programs. Best also considers exposures maintained in single large investments. Stress tests assess the surplus impact of a 20 percent decline in common stock prices and the reduction in market value of bonds, preferred stocks and mortgage loans caused by a two percentage point increase in interest rates.

Best's qualitative evaluation looks at any items which cannot be totally reflected in the "numbers" that may have affected a company's performance or may potentially affect its long-term viability. The qualitative evaluation includes, but is not limited to the:

1) composition of a company's book of business, i.e. spread of risk; 2) adequacy of the reinsurance program; 3) quality, estimated market value and diversification of investments; 4) adequacy of reserves; 5) adequacy of surplus; 6) experience and competency of management; 7) asset/liability matching programs; and 8) the distribution and nature of liabilities structures. Also, Best recently instituted a "policy holder confidence factor" which measures a life insurer's relative vulnerability to all surrenderable liabilities in relation to its liquid assets.

To evaluate a company's spread of risk, Best analyzes its book of business on both a geographic basis and by line of business. Best also reviews a mix of a company's business relative to the distribution of its assets and their respective maturity and expected performance. Best looks for concentration in volatile lines of business or hazardous areas which can negatively affect an insurer's financial stability. Best reviews each insurer's reinsurance program to determine whether coverage is adequate for the potential risks involved.

If an insurer carries a large amount of reinsurance, Best evaluates the quality, diversification and purpose of the reinsurance. An insurer's rating may be adversely affected if it has a large amount of reinsurance or reinsurance recoverable, particularly if the financial condition of the reinsurer is unknown. Significant amounts of reinsurance undertaken primarily for financial reasons also may negatively affect an insurer's rating. Best examines an insurer's marketable assets (common stocks, bonds, mortgage loans) to determine the potential impact on its surplus if an insurer had to sell assets unexpectedly. The liquidity, diversification and quality of assets are evaluated to assess the uncertainty of the value to be obtained on their sale. The adequacy of an insurer's reserves is essential to Best's analysis of its profitability, leverage and liquidity.

For life companies, reserve analysis involves examining the types of business written and the valuation bases and interest assumptions used. For property/casualty companies, Best evaluates the losses and loss adjustment expenses on an ultimate payout basis. Best also considers the magnitude of a company's loss reserve discount relative to its surplus. In addition, the degree of uncertainty in loss reserve, recognizing that they are only actuarial estimates of future events, is evaluated. If the degree of uncertainty exceeds any equity in the reserves and is large in relation to net income and policy holder's surplus, Best's assessment of a company's reported profitability and leverage performance may be adjusted accordingly for rating purposes.

Best assesses the adequacy of an insurer's surplus relative to the degree of risk associated with its book of business. Best's rating evaluation accounts for the fact that varying degrees of underwriting risk and volatility exist with certain lines of business, with lines of higher volatility requiring greater capital adequacy. Best prides itself on close working relationships and frequent contacts with the managements of the companies it reports on and rates.

Best's rating evaluation considers the character, objectives, experience and competence of an insurer's management. Various other important factors may be considered in the qualitative analysis, particularly those which may significantly affect a company's ability to meet its contractual obligations. Best's research and analysis in other areas may identify market or economic trends that could affect an insurer's financial condition. A company's relative standing within a rating category can be weakened, maintained or strengthened, based on the qualitative analysis. In a few instances, an insurer may be precluded from a particular rating classification or downgraded because of severe qualitative concerns.

Rating Classifications: Best has several different rating classification systems. The majority of companies rated receive an alphabetical rating which range from A+ (Superior) to C- (Fair). Double-plus rating categories of A++, B++ and C++ were previously added to the existing A+ rating (Superior), B+ rating (Very Good) and C+ (Fair) rating categories. In addition, rating categories of D (Below Minimum Standards), E (Under State Supervision) and F (In Liquidation) were added to complete a range that now extends from A++ through F.

Insurers that do not receive an alphabetical rating receive an NA classification for various reasons. The former rating categories NA-7 (Below Minimum Standards) and NA-10 (Under State Supervision) were eliminated in 1992. Companies previously rated in these categories were included in the expanded alphabetical ratings. Also, a new category NA-11 (Rating Suspended) was added. A portion of the not assigned companies also received an FPI rating. Best issues reports even for non-rated companies. Best's rating classifications are described below in abbreviated form.

A++ and A+ (Superior): Assigned to those companies which in Best's opinion have achieved superior overall performance when compared to Best's standards. According to Best, A++ and A+ (Superior) rated insurers have a very strong ability to meet their policy holders and other contractual obligations over a long period of time.

A and A - (Excellent): Assigned to those companies which, in Best's opinion, have achieved excellent overall performance when compared to Best's standards. According to Best, A and A- (Excellent) rated insurers have a strong ability to meet their policy holder and other contractual obligations over a long period of time.

B++ and B+ (Very Good): Assigned to those companies which in Best's opinion have achieved very good overall performance when compared to Best's standards. According to Best, B++ and B+ (Very Good) rated insurers have a strong ability to meet their policy holder and other contractual obligations, but their financial strength may be susceptible to unfavorable changes in underwriting or economic conditions.

B and B- (Good): Assigned to those companies which in Best's opinion have achieved good overall performance when compared to Best's standards. According to Best, B and B- (Good) rated insurers generally have an adequate ability to meet their policy holder and other contractual obligations, but their financial strength is susceptible to unfavorable changes in underwriting or economic conditions.

C++ and C+ (Fair): Assigned to those companies which, in Best's opinion, have achieved fair overall performance when compared to Best's standards. According to Best, C++ and C+ (Fair) rated insurers generally have a reasonable ability to meet their policy holder and other contractual obligations, but their financial strength is vulnerable to unfavorable changes in underwriting or economic conditions.

C and C- (Marginal): Assigned to those companies which, in Best's opinion, have achieved marginal overall performance when compared to Best's standards. According to Best, C and C- (Fair) rated insurers have a current ability to meet their policy holder and other contractual obligations, but their financial strength is very vulnerable to unfavorable changes in underwriting or economic conditions.

D (Below Minimum Standards): Assigned to companies which meet Best's minimum size and experience requirements, but do not meet Best's minimum standards for C- rating. Note: This rating category was formerly the NA-7 (Below Minimum Standards) Rating Not Assigned classification.

E (Under State Supervision): Assigned to companies which are placed under any form of supervision, control or restraint by a state insurance regulatory authority such as conservatorship or rehabilitation, but does not include liquidation. May be assigned to a company under a cease and desist order issued by a regulator from a state other than its state of domicile. Note: This rating category was formerly the NA-10 (Under State Supervision) Rating Not Assigned classification.

F (In Liquidation): Assigned to companies which have been placed under an order of liquidation or have voluntarily agreed to liquidate. Note: This was a new rating category in 1992 to distinguish between companies under state regulatory supervision and those in the process of liquidation.

Performance Modifiers: Best assigns modifiers to their alphabetical ratings to identify a company whose assigned rating has been modified because of performance, affiliation or contractual obligations. The full list of modifiers are listed below:

> **"w" Watch List** : Indicates the company was placed on Best's Rating "Watch List" during the year to advise its subscribers that the company is under close surveillance because it has experience a downward trend in its current financial performance or may be exposed to a possible legal, financial or market situation which could adversely affect its performance.
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> **"x" Revised Rating** : Indicates the rating shown was revised during the year.

Affiliation Modifiers:

"e" Parent Rating : Indicates that the rating assigned is that of the parent of a domestic subsidiary in which ownership exceeds 50 percent. The rating is based on the consolidated performance of the parent and its subsidiaries. To qualify for a parent rating, the subsidiary must be eligible for rating based on its own performance after attaining five consecutive years of representative experience; have common management with its parent; underwrite similar lines of business; and have interim leverage and liquidity performance comparable to that of its parent.

"g" Group Rating (property/casualty companies only): Indicates the rating is assigned to an affiliated group of property/casualty companies. To qualify for a group rating, the companies in a group must be affiliated via common management and/or ownership; pool a substantial portion of their net business; and have only minor differences in their underwriting and operating performance. All members are assigned the same rating and financial size category, based on the consolidated performance of the group.

"p" Pooled Rating : Indicates the rating assigned to companies under common management or ownership that pool 100 percent of their net business. All premiums, expenses and losses are prorated in accordance with specified percentages that reasonably relate to the distribution of the policy holders' surplus of each group member. All members participating in the pooling arrangement are assigned the same rating and financial size category, based on the consolidated performance of the group.

"r" Reinsured Rating : Indicates the rating and financial size category assigned to the company are those of an affiliated carrier that reinsures 100 percent of the company's net premiums written.

"s" Consolidated Rating (property/casualty companies only): Indicates the rating is assigned to a parent company and is based on the consolidated performance of the company and its domestic property/casualty subsidiaries in which ownership exceeds 50 percent. The rating applies only to the parent company because subsidiaries are normally rated on the basis of their own financial condition and performance. A.M. Best does not assign an alphabetical rating to a number of insurers because they do not meet certain requirements such as size or operating experience. A list of these not assigned classifications is provided below with brief explanations.

NA-1 Special Data Filing: Assigned primarily to small mutual and stock companies that are exempt from the requirement to file the standard NAIC annual statement. These company reports are based on selected financial information requested by Best, and the majority are submitted via Best's Data Collector under a cooperative program with the National Association of Mutual Insurance Companies (NAMIC) and other supporting organizations.

NA-2 Less than Minimum Size : Assigned to companies that file the standard NAIC annual statement, but do not meet Best's minimum size requirement of writings of $1.5 million for life/health insurers or $1.5 million of surplus for property/casualty insurers.

NA-3 Insufficient Operating Experience : Assigned to a company which meets, or is anticipated to meet, Best's minimum size requirement, but has not accumulated at least five consecutive years of representative operating experience.

NA-4 Rating Procedure Inapplicable: Assigned to a company when the nature of its business and/or operations is such that the normal rating procedure for insurers does not properly apply. Examples are companies writing lines of business uncommon to the life/health or property/casualty field; companies not soliciting business in the United States; companies retaining only a small portion of their gross premium writings; companies which have discontinued writing new and renewal business and have a defined plan to run-off existing contractual obligations; or companies whose sole operation is accepting business written directly by a parent, subsidiary or affiliated insurance company.

NA-5 Significant Change : Assigned to a previously rated company which experienced a significant change in ownership, management or book of business whereby its operating experience may be interrupted or subject to change; or any other relevant event which has or may affect the general trend of a company's operations.

NA-6 Reinsured by Unrated Reinsurer: Assigned to a company which has a substantial portion of its book of business reinsured by unrated reinsurers and/or has reinsurance recoverables from unrated reinsurers which represent a substantial portion of its policy holders' surplus. Exceptions are unrated foreign reinsurers that comply with Best's reporting requirements.

NA-7 Below Minimum Standards: Discontinued in 1992 and replaced by D rating.

NA-8 Incomplete Financial Information: Assigned to a company that is eligible for a rating, but fails to submit complete financial information for the current five-year period under review. This requirement includes all domestic subsidiaries in which the company's ownership exceeds 50 percent.

NA-9 Company Request: Assigned to a company that is eligible for a rating, but requests that the rating not be published. The majority of these companies, such as captives, operate in markets that do not require a rating, but cooperate with Best's request for financial information so that a report can be prepared and published on their company. The classification is also assigned to a company that requests its rating not be published because it disagrees with Best's rating assignment or payment of the $500 rating fee. In this situation, Best's policy normally requires a minimum of two years to elapse before the company is again eligible for the assignment of a rating.

NA-10 Under State Supervision: Discontinued in 1992 and replaced by rating of either E or F.

NA-11 Rating Suspended: Assigned to a previously rated company which has experienced a sudden and significant event affecting the company's financial position and operating performance, of which the impact cannot be evaluated due to a lack of timely or appropriate information. A recent sample distribution of insurers by Best ratings found that of the total companies rated, 41.7 percent of life/health insurers and

52.6 percent of property/casualty insurers were assigned a "Superior" or "Excellent" rating. Of the companies receiving alphabetical or NA-7 (Below Minimum Standards) ratings, 68.8 percent of life/health and 82.9 percent of property/casualty insurers were assigned a "Superior" or "Excellent" rating.

Financial Performance Index (FPI): In the 1990's, A.M. Best instituted the *FPI rating* for companies not meeting the size and operating experience requirements for an alphabetical rating. The FPI is assigned to companies that have three years of representative operating experience, submit NAIC statements, complete a supplemental rating questionnaire and qualify or NA-2 or NA-3 categories. The assignment of the FPI involves the same notification and discussion process with company management as with alphabetically rated companies.

The FPI procedure includes both a quantitative and qualitative review of a company's operating and financial performance. The quantitative evaluation is based on an analysis of a company's financial performance, utilizing essentially the same key tests required for the alphabetical rating. The qualitative review for the FPI rating is not as extensive as that for an alphabetical rating, but it does include adjustments for adequacy of reinsurance protection, geographic spread of risk and loss exposure by product line.

A company is assigned an index of from 1 to 9 based on the quantitative and qualitative review of its overall performance. An FPI of 1 is assigned to a company that does not have three consecutive years of representative operating experience or, in a few cases, was assigned an FPI which was lower than it found acceptable and requested that it not be published.

Dissemination of Rating Information: Best disseminates company reports and ratings through various publications and information services. Best's Insurance Report are published annually and available to consumers through most public libraries and state insurance departments which receive complimentary copies.

Updated year end ratings and interim rating changes are also made available through various subscription publications, weekly, monthly and quarterly; daily through BestLink, the on-line computer network service; and through BestLine, a direct dial 900 rating service. These publications and services are complimented by other Best reports and analyses that deal with industry issues and developments.

STANDARD & POOR'S

Standard and Poor's (S&P) has emerged as the second leading insurer rating agency in terms of the number of domestic insurers rated, with virtually the same number of insurers assigned letter grade ratings as A.M. Best. It has been rating bonds since 1923 and insurance companies' claims paying ability since 1983. S&P's insurer rating activity draws from its experience and procedures in rating debt issues and utilizes a similar classification framework, but is conducted by professional analysts whose background, experience and/or training is focused on the insurance industry.

S&P's philosophy and approach to rating the financial strength of insurers is more like that of Moody's and Fitch Ratings than like A.M. Best. S&P sees its role as one of providing risk assessment of insurers to insurance buyers rather than serving as an advisor to insurers to assist them in improving their financial condition and rating. S&P's Insurance Rating Services is one of six departments within its Ratings Group which has a staff in excess of 700 located in offices in seven countries.

S&P's Insurance Rating Services provides ratings on fixed income securities, including long-term debt, commercial paper and preferred stock issued by insurance companies, as well as claims paying ability ratings and qualified solvency ratings of the financial strength of insurers. S&P's claims paying ability rating is an assessment of an operating insurance company's financial capacity to meet its policy holder obligations in accordance with their terms.

Claims paying ability ratings are based on a comprehensive quantitative and qualitative financial analysis using various sources of information, including interviews with company management. S&P introduced qualified solvency ratings in 1991, after two years of development, to extend its coverage of opinions on insurers in response to market demands for information on insurers for which it did not provide a claims paying ability rating. The qualified solvency ratings are based on a statistical analysis of statutory financial data filed with the NAIC and purchased by S&P.

S&P's qualified solvency methodology provides a solely statistically based indication of financial strength among insurers and differentiates broadly between classes of risk to policy holders. S&P's insurer ratings are not recommendations to buy, retain, or surrender a policy from any particular insurer.

Some regulators and insurers have questioned the fairness of qualified solvency ratings. Conversely, other insurers have referred to their qualified solvency rating, along with other agencies ratings, in sales material or have expressed disappointment in not receiving a qualified solvency rating. Some brokers and agents have expressed the view that qualified solvency ratings are not well understood in the market. S&P notes others have expressed the view that qualified solvency ratings add useful information to the market.

All claims paying ability ratings are voluntary and insurers pay a rating fee that typically ranges from $15,000 to $32,000 depending on size, number of affiliated insurers, and other factors. In connection with their initial application for a claims paying ability rating, insurers have the option of not completing the process and/or not having a claims paying ability rating published.

Once a claims paying ability rating is published, the insurer can request that it be withdrawn, although this option has been very rarely exercised. A statement of S&P's current opinion of the insurer's financial strength will be released at the time of the rating withdrawal. If an insurer requests that its claims paying ability rating be withdrawn because it anticipates that the rating will be lowered, S&P will complete its review process and if a rating downgrade is viewed as warranted, will announce it before withdrawing the rating.

Rating Process: S&P's claims paying ability rating process begins with an application and a commitment from an insurer to provide the necessary financial information for a full evaluation. A lead analyst is assigned to work with the company and obtain financial information including five years of statutory financial statements, GAAP financial statements (if available) information provided on special questionnaires dealing with debt securities, mortgage loans and real estate investments. Various spreadsheets, profiles and financial ratios are prepared to assist S&P analysts in forming an initial opinion about the financial condition of an insurer relative to Best's standards.

S&P analysts also meet with company management to discuss issues relating to the company's business goals and strategies, profitability, underwriting standards, reserving policy, leverage and use of debt, earnings outlook, accounting policies, targeted markets, acquisition and growth philosophy, planning processes, asset distribution and quality, and asset/liability management. In an initial rating, S&P prefers to meet with an insurer for a full day at its headquarters to have full access to the appropriate personnel. Subsequent meetings may be held at the company's location or at S&P.

Subsequent to the management interview, the lead analyst prepares a report and preliminary rating based on a quantitative and qualitative evaluation of all the information compiled. The report is presented to a rating committee comprised of five or more senior insurance industry specialists and also including, when necessary, other S&P specialists in areas such as real estate, private placements and other investments. The rating committee scrutinizes the preliminary rating, questions the analyst's assumptions, verifies the material facts and challenges the analyst's conclusions. After this review, the rating committee makes a final determination on the rating that will be assigned to the insurer.

The insurer is informed of the committee's rating assignment and the basis for the rating. However, the nature of the rating committee's deliberations and the identity of its members are not disclosed to the insurer. If the company can provide additional information and/or demonstrate that the basis for the initial rating was incorrect, the committee may revise its rating decision. Otherwise, the rating stands.

An insurer does have the option of requesting that an initial claims paying ability rating not be published. S&P believes that this option is necessary to ensure that it receives the cooperation of insurers to provide the information that it needs to do a proper evaluation, not only with respect to the initial rating assignment, but in connection with S&P's ongoing rating surveillance as well. S&P indicates, however, that this is an option that has rarely been exercised, and that when exercised, has to date virtually always resulted in ratings in the AA, A or BBB categories not being published. Also, insurers that decline their claims paying ability rating will receive a qualified solvency rating.

Once assigned and approved, insurers' ratings are released through monthly and quarterly publications as well as made available to consumers over the telephone. After a claims paying ability rating is assigned, S&P analysts continue to monitor an insurer's performance for new developments. The surveillance process involves reviewing the insurer's financial statements and reports each year, annual meetings with company management, and monitoring company, industry and market developments.

Any rating may be reviewed at any time when new information suggests that the financial strength of the insurer may have changed. S&P will always notify a company when a rating change is contemplated, and will meet with the company as part of the process leading up to the potential change. S&P also may issue a general advisory, referred to as a "**CreditWatch**", if new developments may affect an insurer's claims paying ability rating. Insurers are always made aware of a rating change or a CreditWatch advisory prior to its release.

Rating Methodology: S&P conducts a comprehensive quantitative and qualitative evaluation in assessing an insurer's financial strength and ability to meet its future obligations to policy holders for the claims paying ability rating. S&P applies a common set of qualitative principles to every company regardless of its line of business, but then tailors its analytical approach to each of the four primary

insurance industry segments: life/health insurers; property/casualty insurers; consolidated property/casualty groups; and professional reinsurers. Its rating methodology profile covers eight basic areas 1) industry risk; 2) management and corporate strategy; 3) business review; 4) operational analysis; 5) investments; 6) capitalization; 7) liquidity; 8) financial flexibility.

S&P also looks at interest rate management and asset/liability matching for life insurers and loss reserve adequacy for property/casualty insurers. Insurers are "benchmarked" against industry norms in the quantitative portion of the evaluation, but there is no specific formula or algorithm used to score companies based on their statistical results.

S&P's industry risk analysis looks at four competitive factors; 1) potential threat of new entrants; 2) threat of substitute products or services; 3) rivalry among existing firms; 4) bargaining power of buyers/suppliers. Industry sectors are defined largely by the type of insurance written. When a company does business in more than one sector, a weighted average risk score is assigned based on premium revenue. With respect to management and corporate strategy, S&P evaluates whether the strategy management has chosen is both consistent with the organization's capabilities and whether it makes sense in its marketplace.

S&P also evaluates a company's operational skills, which essentially involves an assessment of a company's ability to execute its chosen strategy. S&P evaluates management's expertise in operating each of the company's lines of business as well as the adequacy of audit and control systems; its financial risk tolerance, which relates to the amount of debt in its capital structure and the level of operating leverage which a company is willing to accept; its organizational structure, and how it fits the company's strategy.

S&P's business review analysis identifies the company's fundamental characteristics and its source of competitive advantage or disadvantage. This includes a description of the portfolio of business units and/or product lines, distribution systems, and the degree of business diversification. The business review includes analysis of those aspects of the business that affect the absolute level, growth rate and quality of the revenue base and focuses on the long-term revenue generating capabilities of the insurer.

Through an analysis of operating results, S&P determines a company's ability to capitalize on its strategy and company strengths. Operating results are analyzed independently of the firm's operating leverage. S&P's analysis of an insurer's earnings performance focuses on its underlying economic profitability rather than its stated statutory net gain. If available, S&P will review a firm's GAAP financials in making its assessment, although it will rely on statutory figures is GAAP financials are unavailable.

S&P focuses on the after-tax return on assets as the most comprehensive ratio not affected by leverage. For a life/health insurer, S&P's analysis includes a review of its persistency, expense structure, mortality/morbidity experience, effective tax ratio, pricing policies and actual performance versus pricing. For a property/casualty company, S&P examines underwriting performance including premium growth rates, loss ratios, expense ratios, combined ratio and loss reserve adequacy. The trend and stability of a company's earnings are also evaluated.

S&P's analysis of an insurer's investments considers the insurer's allocation of assets among investments such as bonds, mortgages, preferred stock, real estate, common stock and other

invested assets. The assets are evaluated for credit quality and diversification. An insurer's asset allocation is also examined to determine how appropriate it is to support policy holder liabilities. Asset quality is reviewed throughout the investment portfolio, and charges are applied against the insurer's capital for problem and risky assets to establish what S&P believes to be the appropriate level of investment reserves. Delinquencies on mortgage portfolios, restructured mortgage loans, loans in the process of foreclosure and foreclosed real estate are also assessed.

S&P applies a default rate model, based on historical experience and current S&P projections, to determine the appropriate level of investment reserve needed for mortgages, bonds and other fixed income assets. Credit is given for existing investment reserves in the statutory balance sheet. Equity assets, including common stock, real estate, and schedule BA assets, are reviewed for appropriateness of valuation. S&P may adjust capital to reflect what it believes to be over-valued assets or to incorporate hidden asset values.

S&P also evaluates how well an insurer manages its interest rate risk and asset/liability matching strategies relative to its product lines. S&P reviews an insurer's asset/liability management by identifying the specific asset and liability durations and cash flows of interest rate sensitive portfolios. Investment risk and the degree of mismatch between the maturity and duration of the investment portfolio with an insurer's liability structure is principal to S&P's evaluation of management's tolerance for risk.

S&P's analysis of insurers' capitalization incorporates financial leverage and fixed charge coverage concepts as well as the degree of operating leverage. The ratios used by S&P for all insurers are total debt to capital; long-term debt to capital; short-term debt to capital; fixed charge coverage; preferred stock to capital; and fixed charge coverage of preferred dividends. The analysis of operating leverage is analyzed in relation to the business lines of an insurer. For life/health insurers, operating leverage is defined as total liabilities to statutory capital, treating the mandatory securities valuation reserve (MSVR) as capital and excluding separate accounts from liabilities. For property/casualty insurers, the applicable ratios are net written premiums to surplus; loss reserves to surplus; loss reserves to earned premiums; ceded written premium to gross written premium; and investments in subsidiaries/affiliates to surplus. Other risks inherent in an insurer's operations such as asset/liability mismatch are also examined in relation to the level of capital. In addition, the use and quality of reinsurance is analyzed.

Finally, the quality of capital is analyzed in terms of the degree of exposure to reinsurers and equity assets such as common stocks, including investment in affiliates, real estate equities, and equity investments in partnerships relative to the capital base of the firm.

Property/casualty insurers' loss reserves are also evaluated for adequacy. S&P's loss reserve analysis looks at six lines individually and combined utilizing data filed on Schedule P: personal auto liability; commercial auto liability; other liability; medical malpractice; workers' compensation; and commercial multi-peril.

S&P utilizes several different standard techniques to arrive at a degree of confidence in the loss reserve for each line and to identify areas where management will be asked to explain deviations from expected results. In evaluating liquidity for life insurers, S&P focuses on an insurer's ability to handle reasonable increases in cash outflows due to lapses, surrenders, policy holder loans or other cash withdrawals. S&P analyzes the nature of a company's policy holder liabilities and their associated surrender charges and/or market valuation charges in determining the susceptibility to

increased cash outflows before policy maturity. In addition, it looks at the maturity structure of large dollar investment-oriented contracts such as guaranteed investment contracts (GICs) in evaluating a company's liquidity needs.

The amount of liquid assets available to meet increased cash outflows and policy maturity are compared. S&P defines liquid assets to include cash and short-term securities; government and government-backed securities; investment grade public bonds; private placements in NAIC categories 1 or 2 maturing in one year or less; and other liquid assets as determined by S&P through discussions with management.

The liquidity ratios examined by S&P for life/health insurers include operating cash flow to benefits paid; operating cash flow to liabilities; and cash and short-term investments to invested assets. For property/casualty insurers, S&P looks at underwriting cash flow to sources/uses; total cash flow to sources/uses; and cash and short-term investments to invested assets.

Finally, S&P evaluates an insurer's financial flexibility in terms of its capital requirements and capital sources. Capital requirements refer to factors that may give rise to an exceptionally large need for either long-term capital or short-term liquidity. Capital sources involve an assessment of the extent to which a company has access to short and long-term capital beyond normal operating earnings and cash flow.

Rating Classifications And Distribution Claims-Paying Ability Ratings: As indicated above, S&P provides either of two types of ratings of an insurer's financial strength: a claims paying ability rating or a qualified solvency rating. The claims paying ability rating is an opinion of an insurer's financial capacity to meet the obligations of its insurance policies in accordance with their terms.

Claims paying ability ratings are further divided into two classifications: secure and vulnerable. Rating categories from "AAA" to "BBB" are classified as "secure" claims paying ability ratings and are used to indicate insurers whose financial capacity to meet policy holder obligations is viewed on balance as sound. Rating categories from "BB" to "D" are classified as "vulnerable" claims paying ability ratings and are used to indicate insurers whose financial capacity to meet policy holder obligations is viewed as vulnerable to adverse developments. In fact, the financial capacity of insurers rated "CC" to "C" may already be impaired, while insurers rated "D" are in liquidation. Ratings from "AA" to "CCC" may be modified by a plus or minus sign to show the relative standing of the insurer within those rating categories. The specific claims paying ability ratings are further described below:

> **AAA** : Insurers rated AAA offer superior financial security on both an absolute and relative basis. They possess the highest safety and have an overwhelming capacity to meet policy holder obligations.
>
> **AA** : Insurers rated AA offer excellent financial security, and their capacity to meet policy holder obligations differs only in a small degree from insurers rated AAA.
>
> **A** : Insurers rated A offer good financial security, but their capacity to meet policy holder obligations is somewhat more susceptible to adverse changes in economic or underwriting conditions than more highly rated insurers.

BBB : Insurers rated BBB offer adequate financial security, but their capacity to meet policy holder obligations is considered more vulnerable to adverse economic or underwriting conditions than that of more highly rated insurers.

BB : Insurers rated BB offer financial security that may be adequate but caution is indicated since their capacity to meet policy holder obligations is considered vulnerable to adverse economic or underwriting conditions and may not be adequate for "long-tail" or long-term policies.

B : Insurers rated B are currently able to meet policy holder obligations, but their vulnerability to adverse economic or underwriting conditions is considered high.

CCC : Insurers rated CCC are vulnerable to adverse economic or underwriting conditions to the extent that their continued capacity to meet policy holder obligations is highly questionable unless a favorable environment prevails.

CC and C : Insurers rated CC and C may not be meeting all policy holder obligations and may be operating under the jurisdiction of insurance regulators and are vulnerable to liquidation.

D : Insurers rated D have been placed under an order of liquidation.

Qualified Solvency Ratings: S&P's qualified solvency ratings are based strictly on the application of statistical analysis to statutory financial data filed by insurers with the NAIC. The objective of the statistical analysis is to distinguish insurers that are financially weak or more likely to get into financial trouble from insurers that are financially strong or less likely to encounter financial difficulty.

Multi-variety discriminant analysis is used to develop a model which assigns a numerical score (Z-score) to each insurer based on its financial results. The financial ratios or variables which comprise the model are measured over a four-year period to incorporate trend. The model is tested using alternate data sets to affirm its stability and ability to predict failed insurers.

The analysis is conducted separately for the four different industry segments: consolidated property/casualty insurers; individual property/casualty insurers; professional reinsurers; and life/health insurers. The procedures used were reviewed by independent actuarial and accounting consultants. The models used are updated as new data become available and the characteristics of failed and solvent insurers change over time.

Insurers' Z-scores are divided into three broad groups. Insurers with the highest scores are assigned a BBBq rating indicating "adequate" financial security. Their scores most closely resemble those of financially strong insurers. The next segment of scores is assigned a BBq rating, indicating that financial security "may be adequate". Insurers receiving the lowest scores are rated Bq, indicating a "vulnerable" financial condition. Their scores most closely resemble those of insurers that have actually experienced financial difficulty.

Insurers that do not voluntarily apply for a claims paying ability rating are assigned a qualified solvency rating based on a quantitative analysis of their statutory financial data. Qualified solvency ratings are computed for individual insurers on a stand-alone basis, without consideration for strength or weakness that might be added by a parent or affiliated companies. Qualified solvency rating designations range from BBBq to Bq. The "q" suffix indicates the qualified nature of the rating

because it is based strictly on a statistical analysis. The definitions of the qualified solvency ratings are given below:

> **BBBq** : Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing adequate or better financial security.
>
> **BBq** : Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing financial security that may be adequate.
>
> **Bq** : Results of quantitative tests on the insurer's statutory financial results are consistent with those of insurers providing vulnerable financial security. S&P has been criticized by some insurers and regulators because the highest qualified solvency rating possible is BBBq which appears to be lower than the highest claims paying ability rating possible, AAA. However, S&P's rationale for the use of B-range symbols for qualified solvency ratings is that they are consistent with the definitions of S&P's claims paying ability ratings.

In S&P's Insurer Solvency Review, it points out that a BBB claims paying ability is considered secure, but not superior. Similarly, a BBBq rating is presumed to represent a secure insurer, although it is uncertain how secure based on its statistical analysis alone. S&P acknowledges, "It is possible that a more comprehensive evaluation would reveal that a BBBq-rated insurer could be rated BB or lower on the claims paying ability rating scale. It is most likely, however, that an insurer rated BBBq would be rated among the top four categories (AAA to BBB) for claims paying ability."

S&P describes insurers rated BB for claims paying ability as providing "financial security that may be adequate but caution is indicated since their capacity to meet policy holder obligations is considered vulnerable to adverse economic or underwriting conditions..." S&P links that definition to its BBq qualified rating, indicating that insurers rated BBq appear weaker than insurers rated BBBq but, nonetheless, offer financial security that may be adequate.

The most likely range of claims paying ability rating is A to B. S&P's definition of a B claims paying ability rating says: "Vulnerability to adverse economic or underwriting conditions is considered high." A Bq rating is intended to convey a similar notion. Insurers rated Bq show material weaknesses according to the financial data, similar to insurers that have encountered financial difficulty in the past. However, just as some insurers rated BBBq in reality may be weaker than the data suggest, it is probable that some insurers rated Bq may in fact be stronger than the data suggest.

Nevertheless, insurers with qualified solvency ratings of Bq would, on their own merits, be least likely to receive claims paying ability ratings in the "secure" range of BBB or higher. S&P contends that consumers properly understand the distinction between the claims paying ability and qualified solvency ratings. However, some insurers and regulators believe that consumers tend to equate the two.

No research has been conducted to determine whether consumers properly understand the difference between the two types of ratings. S&P bases its conclusions on telephone contacts with consumers. Because of concerns about consumer misperceptions, some insurers and industry trade associations indicate that they feel coerced to "purchase" a claims paying ability rating the fee for which typically ranges from $22,000-$28,000 and which may be different than their qualified solvency rating. Some insurers have claimed that it is unfair to subject them involuntarily to a statistically based rating and to be confined to a qualified B-range rating because they have not paid for a more in-

depth claims paying ability rating. Some smaller insurers express additional concerns that S&P's qualified solvency rating model tends to favor larger insurers.

However, S&P believes that the qualified solvency methodology provides an unbiased indication of insurers' financial strength and can differentiate broadly between classes of risk to policy holders. It further maintains that the classification framework used for the qualified solvency rating is appropriately conservative to protect consumers. In a recent sample distribution of claims paying ability and qualified solvency ratings, of the total companies rated, 16 percent of life/health and 19 percent of property/casualty companies received an AAA (Superior) or AA (Excellent) rating. Of the companies receiving claims paying ability ratings, 78.1 percent of life/health and 75.6 percent of property/casualty insurers received an AAA or AA rating.

Dissemination of Rating Information: S&P disseminates its ratings and other financial information about insurers through several publications. S&P's Insurance Book is a quarterly looseleaf service providing comprehensive coverage of more than 500 insurance companies: property/casualty, life/health, reinsurance, bond insurance and mortgage insurance. S&P's Insurance Digests are quarterly publications containing capsule reports on S&P-rated companies. S&P's Insurers Ratings List is a monthly publication listing all of S&P's insurer claims paying ability ratings by industry. Select Reports are four-page reports, excerpted from S&P's Insurance Book, containing a full, in-depth review of each company. Consumers also can obtain information on up to five insurers at a time, free of charge, by calling S&P's Rating Information Department.

MOODY'S INVESTOR SERVICE

Moody's Investors Service was founded in 1900 by John Moody, who invented bond ratings in 1909. Today, Moody's rates securities of some 4,000 industrial companies, public utilities, banks and other financial institutions. In addition to bonds, Moody's rates the credit worthiness of a wide variety of financial obligations, such as commercial paper, bank deposits, money market funds and GICs.

In the insurance sector, Moody's has been rating the debt securities of insurance companies since the mid-1970s. Moody's began assigning insurance company financial strength ratings in 1986. Although Moody's rates fewer insurers than A.M. Best or S&P, it has acquired a solid reputation for thoroughness and expertise in its insurer rating activities.

Moody's financial strength ratings reflect its opinion as to an insurer's ability to discharge senior policy holder obligations and claims. It seeks to measure "credit risk", i.e., the risk that an insurer will fail to honor its senior policy holder claims in full and on a timely basis. Moody's financial strength ratings are based on quantitative and qualitative analysis of the industry, regulatory trends and the business fundamentals of the insurer.

Insurers can apply to Moody's for a financial strength rating. There is a basic annual appraisal fee of $25,000 for life insurance financial strength ratings and $22,000 for property/casualty financial strength ratings. In addition, where Moody's believes there is sufficient policy holder and investor interest, Moody's is prepared to assign financial strength ratings to life companies that have not requested a rating.

Although Moody's will generally solicit the company's cooperation under such circumstances, Moody's is prepared to go forward without company participation on the basis of publicly available

information. Moody's will only do so if adequate information is available in the public domain to reach a credible rating conclusion. Moody's does not charge a fee, at least initially, to insurers that have not applied for a rating.

Moody's primary focus on the life side has been insurers that are large annuity writers, but it is expanding into other segments of the life industry and also has rated property/casualty insurers. Moody's financial strength ratings and debt ratings for insurers are produced by its Insurance Group, which is part of its Financial Institutions Group. Moody's committee rating process also utilizes expertise of other Moody's staff and management in analyzing and rating insurers.

Rating Process: In assigning financial strength ratings to insurers, Moody's employs a committee process that draws upon the perspective and expertise of a number of analysts, associate directors and directors. The lead analyst is responsible for analyzing the insurer and preparing a rating recommendation to Moody's Corporate Rating Committee. This committee is ultimately responsible for the final rating decision.

Once a committee decision is reached, the insurer is informed of the decision, and the rating is usually released to the public shortly thereafter. Once a rating has been assigned, it is considered to be "continuously under review", and it can be changed if Moody's becomes aware of developments within the company, the industry, or any other general developments that Moody's believes could change the fundamental risk embodied in the rating. Moody's analysis typically, but not always, involves meeting with the company management.

Insurers are given the right to appeal first-time financial strength ratings and to meet with Moody's staff to disclose new information that may be relevant to the rating decision. However, since 1992, Moody's has reserved the right to disclose an insurer's rating, whether the insurer agrees with its rating or not. When entering new areas, Moody's has initially given insurers the option of not having their rating published until a "framework of comparability is achieved within the given sector". Recently, Moody's determined that its rating coverage of U.S. life insurers has met this standard and, therefore, it no longer offers the refusal option to life insurers. It does still offer the refusal option to property/casualty insurers.

Rating Methodology: Moody's financial strength ratings are based on industry analysis, regulatory trends and an evaluation of an insurer's business fundamentals. Its industry analysis examines the structure of competition within the insurer's operating environment and its competitive position within that structure. The analysis of regulatory trends attempts to develop an understanding of potential changes in a particular country's regulatory system and tax structure. The analysis of a company's business fundamentals focuses primarily on financial factors, "franchise value", management and organizational structure/ownership.

In conducting its industry analysis Moody's looks at a number of factors, including: the degree of concentration within the industry; the extent of inter-industry competition; the degree to which competition is likely to remain orderly and the level of national protectionism, explicit or implicit.

Moody's analysis of regulatory trends includes consideration of potential changes in regulations or taxation that could inhibit an insurer's competitive position or could lead to a significant restructuring of segments of the industry. Moody's also considers the failure-resolution practices of state regulators in its overall financial strength rating.

Moody's analysis of the financial fundamentals of a company encompasses capital adequacy, investment risk, profitability and liquidity. To assess capital adequacy, Moody's adjusts an insurer's statutory data to estimate its economic capital as a going concern. Adjustments include consideration of the conservatism in statutory reserves and asset valuation, acquisition costs recoverable from future earnings, hypothecation of future earnings through financial reinsurance, and investments in subsidiary companies. Moody's also employs a risk-based benchmark capital ratio to assess capital adequacy which recognizes an insurer's mix of lines of business and assets, each of which has varying risk characteristics, including asset default, pricing adequacy, and interest rate risk. Moody's assesses a number of factors to reach conclusions about an insurer's expected long-run profitability and the risk that actual results may differ from expected profits. The factors assessed include 1) market focus of the insurer; 2) competitive dynamics in each market segment; 3) relative distribution costs; 4) underwriting record and outlook; 5) investment strategy.

Moody's liquidity analysis attempts to understand the liability structure of the company, the options that may exist in the liabilities, and the degree to which the company's liabilities are confidence-sensitive. For life companies, when there is a high proportion of confidence sensitive policy holders, Moody's analyzes the company's assets. It considers an insurer's asset structure and its "cushion" of a large portfolio of liquid, marketable assets as well as alternative sources of liquidity for a company.

Moody's qualitative evaluation of an insurer also includes an assessment of its "franchise value", management and its organizational structure. In assessing an insurer's franchise value, Moody's looks at its competitive position in its marketplace. This involves assessing the quality of the company's products and distribution systems, and whether its product or service is essential. Moody's also will evaluate whether the company has sustainable competitive advantages in its key lines of business.

Moody's evaluation of management considers its financial track record in such areas as investment risk taking, profitability, and product innovation. Management's strategy, as measured by rapid growth or new business development, is also assessed. Moody's also examines an insurer's relationship to a parent, to subsidiaries or affiliate companies to assess their impact on the financial strength of the insurer. If an insurer is part of a holding company structure, its financial strength rating will typically be constrained by the senior long-term debt rating of the holding company.

Rating Classification & Distribution: Moody's uses the same *symbols* for its insurer financial strength ratings and bond quality ratings. The rating gradations are broken down into nine symbols, each symbol representing a group of ratings in which the quality characteristics are considered to be broadly the same. Numeric qualifiers (1- 3) further distinguish insurance within the rating symbol. The rating symbols are divided into two distinct segments: strong companies (Aaa-Baa) and weak companies (Ba-C). Moody's rating symbols and descriptions are listed below:

> **Aaa**: Insurance companies rated Aaa offer exceptional financial security. While the financial strength of these companies is likely to change, such changes as can be visualized are mostly unlikely to impair their fundamentally strong position.
>
> **Aa**: Insurance companies rated Aa offer excellent financial security. Together with the Aaa group, they constitute what are generally known as high-grade companies. They are rated lower than Aaa companies because long-term risks appear somewhat larger.

A: Insurance companies rated A offer good financial security. However, elements may be present which suggest a susceptibility to impairment sometime in the future.
Baa: Insurance companies rated Baa offer adequate financial security. However, certain protective elements may be lacking or may be characteristically unreliable over any great length of time.

Ba: Insurance companies rated Ba offer questionable financial security. Often the ability of these companies to meet policy holder obligations may be very moderate and thereby not well safeguarded in the future.

B: Insurance companies rated B offer poor financial security. Assurance of punctual payment of policy holder obligations over any long period of time is small.

Caa: Insurance companies rated Caa offer very poor financial security. They may be in default on their policy holder obligations or there may be present elements of danger with respect to punctual payment of policy holder obligations and claims.

Ca: Insurance companies rated Ca offer extremely poor financial security. Such companies are often in default on their policy holder obligations or have other marked shortcomings.

C: Insurance companies rated C are the lowest rated class of insurance company and can be regarded as having extremely poor prospects of ever offering financial security.

Dissemination of Rating Information: Moody's disseminates its ratings through various publications and over the telephone. The public can obtain Moody's ratings, free of charge, by calling its public ratings desk. Moody's Life Insurance Credit Research Service includes detailed reports on insurers, special comments on the industry, and access to analysts. Moody's Life Insurance Handbook contains summary credit opinions of all rated life insurers.

FITCH RATINGS

Fitch Ratings, located in New York and London, is another well-known rater of securities that branched into rating insurers' financial strengths. Fitch has been providing investment research since 1913. They were the first to introduce the now familiar "AAA" to "D" ratings scale in 1924. A merger with IBCA (London) in 1997 followed by the acquisition of another well-known ratings company (Duff & Phelps) in 2000 brought worldwide presence.

These acquisitions strengthened Fitch's coverage in the corporate, financial institution, insurance and structured finance sectors. Fitch's philosophy and approach are similar to that of S&P and Moody's in terms of its risk assessment of insurers from the standpoint of insurance buyers. They emphasize a very thorough qualitative analysis along with quantitative analysis in conducting its rating evaluation.

A Fitch's claims paying ability rating reflects Fitch's opinion as to the likelihood of payment of policy holder and contract holder obligations in accordance with the terms of such obligations. Insurers apply to Fitch to obtain a claims paying rating and are required to pay an annual fee, in addition to agreeing to supply the necessary financial and other information. However, Fitch has rated carriers that did not apply for a rating. Insurers also can opt not to have their rating published although no company is currently in that status.

Rating Process: Insurers are subject to a thorough quantitative and qualitative evaluation in Fitch's rating process. The rating process starts with an application from the insurer. This is followed by a Fitch request for financial information including:

- Current year budget covering expected statutory performance, and, if available, current five-year projections with assumptions.
- Materials that will help to illustrate the asset/liability matching process, including investment policy and methods for estimating asset and liability durations.
- Current New York Regulation 126 filing.
- Listings of problem loans/assets for each major asset class.
- Organizational charts covering corporate structure and principal executive reporting lines.
- Descriptive materials concerning key products.
- Strategy statement by product line.
- Distribution of bond assets by quality ranking, industry category and other categories perceived to be important.
- History of the company focusing on major milestones.
- Any available relative industry comparison statistics on investments, expenses, market share, etc.
- Long form (including all schedules) annual statements for most recent six years. Separate annual statements for subsidiary organizations for most recent year.
- Separate account statements for most recent two years. Separate account statements for subsidiaries for most recent year.
- Quarterly statutory statements for current and preceding year. Also, subsidiaries' quarterlies.
- Most recent insurance department triennial examination report.
- Annual shareholder reports, 10Ks (current and preceding year 100s) for most recent six years and current proxy and recent prospectus.
- Most recent two years audited SAP and GAAP financial statement for entity being rated.
- Annual policy holder reports for most recent two years.

After the information has been received, Fitch representatives visit the insurance company for an initial on-site interview. During that meeting, Fitch representatives talk with key management personnel including the chief executive officer, chief financial officer, chief investment officer, chief marketing officer and product managers. In special situations, company officials are also invited to Fitch headquarters in New York to meet with members of the Fitch rating committee.

Upon receiving the insurer's financial data, Fitch analysts conduct a number of tests that include comparative analysis and financial ratios in areas such as profitability, operating efficiency, investment risk, leverage and liquidity. The analysts also conduct an extensive qualitative evaluation of the company's management, competitive position, economic fundamentals, ownership structure and asset/liability management practices. There also is considerable cross comparison of quantitative and qualitative factors to reach an analytical judgment as to the financial condition of the insurer.

Upon completing their evaluation, Fitch analysts present a report and initial rating recommendation to the Fitch rating committee. The rating committee, consisting of 11 senior credit rating company officers, reviews the analysts' report and recommendation and determines a rating. The rating and an analysis is presented to the insurance company. The company has the option of not having the rating

published, but currently no companies are in that status. Insurer ratings are then disseminated over the telephone, through electronic mail, press releases and Fitch publications. Insurers are also allowed to distribute their Fitch rating and report.

After its initial rating is completed, insurers are subject to ongoing review. This includes obtaining quarterly updates of financial information as well as annual reviews. In addition, Fitch insists on being informed of any significant developments affecting the company to be able to assess their impact and support the rating.

Rating Methodology: Analysis of an insurance company's claims paying ability is "closely allied" to credit analysis at Fitch. The process emphasizes analysis of the company's future ability to pay its policy and contract obligations when they are expected to come due. Confidence in an insurer's long-term solvency and its ability to maintain adequate liquidity are critical considerations in Fitch's review.

Fitch's assessment of an insurer's claims paying ability is based on both quantitative and qualitative analysis. Moreover, interaction between Fitch analysts, senior credit rating committee members and senior management of the company being rated is central to the rating process. Critical areas of analysis are an assessment of the rated company's capital adequacy and the ability to maintain adequate capital in future years; review of investment returns; review of the liability structure (principally statutory reserves) with heavy emphasis on the inherent stability of such liabilities; an assessment of asset and liability management practices including scenario testing in connection with controlling interest rate risk over a range of possible interest rate scenarios; a detailed review of liquidity management and "worst case" scenario testing; analysis of profitability, tax issues, product line returns, reinsurance relationships and marketing strategy; and an actuarial review of product design, pricing and performance together with interest rate crediting practice. In addition, historical, current year-to-date and budgeted financial results are reviewed together with long-range strategic forecasts.

The purpose of this review and analysis is to develop a set of financial performance expectations for the company being rated reflecting the prospective nature of the rating. The subsequent monitoring of the assigned rating and a company's financial performance is a continuing process with actual financial performance regularly compared to expectations. Ratios included in Fitch's quantitative tests are:

- Return on Average Admitted Assets
- Return on Adjusted Surplus
- Net Investment Income Yield
- Combined Ratios
- Expense Ratios
- Surplus Formation
- Higher Risk Assets to Adjusted Surplus
- Investment in Affiliates to Adjusted Surplus
- Premiums to Adjusted Surplus
- Adjusted Liabilities to Adjusted Surplus

In determining adjusted surplus, Fitch sums a company's reported surplus, mandatory securities valuation reserve, deficiency reserves, and other balance sheet items which it considers to represent "capital" employed. Fitch's rationale on these adjustments is to identify and measure total capital employed and thus measure both profitability and operating leverage on a basis consistent with a

company's economic reality. Surplus formation measures growth in adjusted surplus relative to the growth in adjusted liabilities.

A ratio of 1.00 indicates that adjusted surplus and adjusted liabilities are increasing at equivalent rates. A ratio of less than 1.00 implies increased use of operating leverage as the growth in liabilities exceeds the growth in adjusted surplus.

Fitch's rating evaluation also places considerable emphasis on qualitative factors including:

- Economic fundamentals of the company's principal insurance lines;
- Company's competitive position;
- Management capability;
- Relationship of the rated entity to either parent, affiliate, or subsidiary; and
- Asset and liability management practices.

Ultimately, Fitch's rating conclusions rest on integration of the quantitative and qualitative factors in a company's picture. In Fitch's view, the critical consideration in rating is the analytical judgment as to whether historical trends will persist or reverse themselves.

A company with sharply declining profitability measures would normally have a lower claims paying ability rating than a company with either lower and stable or lower and increasing profitability measures. Conversely, a company with higher absolute but stable leverage could receive a higher claims paying ability rating than a company with lower but increasing leverage.

Fitch also is very attentive to an insurer's sensitivity or exposure to both underwriting and business cycles. For example, it notes that the profitability of a life insurer's group accident and health business is typically very sensitive to competition induced rated inadequacy, inflation-driven increases in claim costs, and business cyclerelated reductions in client company employment levels. Similarly, an insurer's assets and liabilities are highly sensitive to interest rate changes, which is the principal factor accounting for balance sheet volatility. Consequently, Fitch focuses on asset and liability mismatches and management techniques to control interest rate risk. It also is concerned with measuring the adequacy of a company's adjusted surplus relative to the effects of this volatility.

Finally, Fitch will weigh certain factors differently in making a rating judgment depending on the circumstances. A company with either demonstrated significant parent support or well above average stability as gauged by trend and volatility, the absolute level of leverage would normally take on less importance in reaching a rating decision than for a company for which these circumstances were not present.

Rating Classification and Classification Distribution: The rating scale that Fitch uses for its claims paying ability ratings is the same as the one it uses for bonds and preferred stock although different definitions of safety are used. Fitch's claims paying ability rating concerns only the likelihood of timely payment of policy holder and contract holder obligations and is not intended to refer to the ability of either the rated company, or as the case may be, a parent, affiliate, subsidiary, etc., to pay non-policy/contract holder obligations. A scale from AAA to CCC is used with "+" to "-" signs to further delineate quality within the broad alphabetical categories. Fitch's ratings and definitions are provided below:

AAA: Highest claims paying ability. Risk factors are negligible.

AA: Very high claims paying ability. Protection factors are strong. Risk is modest, but may vary slightly over time due to economic and/or underwriting conditions.

A: High claims paying ability. Protection factors are average, and there is an expectation of variability in risk over time due to economic and/or underwriting conditions.

BBB: Below average claims paying ability. Protection factors are average. However, there is considerable variability in risk over time due to economic or underwriting conditions.

BB: Uncertain claims paying ability and less than investment grade quality. However, the company is deemed likely to meet these obligations when due. Protection factors will vary widely with changes in economic and/or underwriting conditions.

B: Possessing risk that policy holder and contract holder obligations will not be paid when due. Protection factors will vary widely with changes in economic and underwriting conditions or company fortunes.

CCC: There is substantial risk that policy holder and contract holder obligations will not be paid when due. Company has been or is likely to be placed under state insurance department supervision.

Dissemination of Rating Information: Fitch disseminates financial and rating information on insurers through several means, including telephone inquiries, electronic transmission, press releases, company reports and two publications. The Insurance Company Claims Paying Ability Rating Guide, issued quarterly, contains detailed reports, financial information and ratings for all Fitch rated insurers. There is also a monthly Rating Guide which provides claims paying ability ratings for insurers as well as ratings for long-term and short-term debt instruments and preferred stock. In addition, the public can telephone Fitch free of charge to obtain insurer ratings and an explanation of what the ratings mean.

WEISS RESEARCH

Weiss Research, located in West Palm Beach, Florida, is somewhat different from the other insurance company raters discussed in this paper in terms of its approach. Its founder, Martin D. Weiss, has been publishing newsletters about money markets, interest rates, bank safety and economic forecasting since 1971. In 1989, Weiss began publishing "safety ratings" of life, health and annuity insurers.

Weiss' methodology and rating scale has generated some controversy within the industry. Weiss' safety rating indicates its opinion regarding an insurer's ability to meet its commitments to its policy holders not only under current economic conditions, but also during a declining economy or in an environment of increased liquidity. A computer model comprised of some 200 financial ratios is used to determine an insurer's rating.

The data for the model is obtained from statutory statements and other supplemental financial information provided by insurers. Weiss stresses that it bases its analysis exclusively on objective, quantifiable information. It eschews interjecting subjective and unquantifiable judgment into the rating

process. Consequently, unlike other raters, Weiss does not interview insurer's management nor utilize other subjective information.

Weiss believes that good management will produce good results and that bad results cannot be explained away by management. Weiss' ratings are essentially involuntary. Insurers do not apply to Weiss for a rating, nor do they pay a fee for being rated. Weiss supports its insurer rating activities through the sale of its rating information to the public. Weiss believes that this approach allows it to be independent in its rating evaluation.

A more detailed description of Weiss' rating process, methodology and classification scheme follows.

Rating Process: Weiss follows a five-step process to arrive at a rating. The process begins with data collection. Weiss obtains quantitative information on insurers from several sources including 1) statutory data in computerized form from the NAIC; 2) statutory annual and quarterly data not provided by the NAIC; 3) supplemental data from surveys sent to the companies; and 4) additional data supplied by the companies.

The next step in the process is data validation. This involves running crosschecks on data to identify errors, which are corrected by reference to the hard copy statement or by contact with the company. Data is then mailed to the companies for validation. The next steps are ratio analysis and modeling. The modeling procedure involves automated generation of ratings through a hierarchical series of calculations involving weighting, capping and filtering of the ratios.

Weiss describes its rating system as a pyramid. At the top of the pyramid is the overall rating. This rating is composed of several indexes. Each index, in turn, is derived for a series of "components". The components are based upon several "subcomponents". The subcomponents are derived from the statutory data and data from the companies. The last step is "reality checking". This involves manual verification of the results and modifications of the overall model so that all companies are affected fairly.

The results of Weiss' analysis and its ratings are sent to the companies with a request that the data be examined and verified. Some companies do not respond to these requests and others may object to the rating. Insurers are invited to visit Weiss Research to discuss the rating methodology and conclusions. Insurers are requested to provide new, objective and verifiable information, which will be put into the process and evaluated along with other data.

Once finalized, Weiss ratings are communicated over the telephone and through several publications and software to consumers, agents and others. Review of the insurer also continues. Weiss Research receives quarterly reports from the insurance companies. New information is added to the analytical process and is reported in quarterly updates.

Rating Methodology: Weiss' rating model utilizes five key indices: 1) risk adjusted capital; 2) profitability; 3) liquidity; 4) spread of risk; and 5) sources of capital. Weiss utilizes two risk adjusted capital ratios to determine a company's exposure to investment liquidity and insurance risk in relation to the capital the company has to cover those risks.

The first risk adjusted capital ratio evaluates the company's ability to withstand a moderate economic decline. The second ratio evaluates the company's ability to withstand a severe economic decline. To calculate these risk-adjusted capital ratios, Weiss sums all of the company's resources that could be used to cover losses. These resources include capital, surplus, MSVR, and a portion of the provision

for future policy holders' dividends, where appropriate. Additional credit may also be given for the use of conservative reserving assumptions and other "hidden capital" when applicable. Next, Weiss determines the company's target capital.

This answers the question: Based on the company's level of risk in both its insurance business and its investment portfolio, how much capital would it need to cover potential losses during a moderate economic decline? For Weiss, an average recession is one in which the real gross national product (GNP) declines by about the same amount as it did in the postwar recessions of 1957-58, 1960, 1970, 1974-75, 1980 and 1981-82.

The first risk-adjusted capital ratio is equal to capital resources divided by target capital. If a company has a risk-adjusted capital ratio of 1.0 or more, it means the company has all of the capital Weiss believes that it requires it to withstand potential losses which could be inflicted by a moderate economic decline. If the company has less than 1.0, it does not currently have all of the basic capital resources Weiss thinks that it needs.

Weiss notes that during times of financial distress, companies often have access to additional capital through contributions from a parent or holding company, current profits or reductions in policy holder dividends. Therefore, an allowance is made in the rating system for firms with somewhat less than 1.0 risk-adjusted capital.

The second risk-adjusted capital ratio is equal to capital resources divided by target capital calculated under conditions of severe economic decline. According to Weiss, a severe recession is a prolonged economic slowdown in which the single worst year of the postwar period is extended for a period of three years. This ratio is then converted into an index measured on a scale of zero to 10, with 10 being the best and seven or better considered strong.

A company whose capital, surplus, MSVR and other capital reserves equal its target capital will have a risk-adjusted capital ratio of 1.0 and a risk-adjusted capital index of 7.0. Weiss' profitability index also is a major factor in measuring the financial strength of an insurer and is derived from an analysis of the following five components: 1) the adequacy of investment income; 2) average and weighted average of net gain on operations over the past five years; 3) volatility of operating gains; 4) contribution of gains to capital growth; and 5) control over expenses, in relation to anticipated norms.

The adequacy of investment income to meet the interest requirements of policy reserves is measured in the same way as IRIS ratio 4. It compares the interest credited to life and annuity, health and deposit funds (such as GICs) with the company's investment income to determine whether the company's investment income adequately covers its needs. If income levels are inadequate, the rating will be adversely impacted.

Significant margins above the break-even point have a positive impact on the profitability index. The average and weighted gain on operations look at the overall profit levels of the company over a five-year period. They are measured in terms of return on assets and return on equity. Weiss looks for stable, consistent profits and does not give additional credit for return on equity figures above the 7.5 percent level. A subcomponent is the difference between the straight average and weighted average of net gains. This reveals the profit trend.

If the weighted average is greater than the straight average, profits are generally improving. An uptrend favorably affects the profitability index, helping to offset the negative impact of net loss in the

current period. Conversely, a downtrend with marginal current profits may have a negative impact on the profitability index. With respect to volatility of profits, credit is given for a low standard deviation. Conversely, large swings in operating results are viewed negatively. Additionally, volatile operating gains are viewed as a possible indicator of surplus relief insurance. Additional deductions are made for weighted aggregate operating losses over the last five-year period.

The sources of a company's capital are viewed as an important barometer of a company's financial health. Weiss believes that a company should fund its growth internally from its profits. Contributions from stockholders and/or parent corporations and capital gains are also considered positive factors. However, gains from surrenders, large amounts or reinsurance with non-affiliates and changes in reserve valuation basis are viewed negatively. These and other sources of capital are weighted to produce an index that measures the quality of capital sources. Weiss sees control over expenses as a key indicator of management's skill in controlling operations.

In the Weiss analysis, based on studies by the Canadian Institute of Actuaries, average expenses are derived by function and by line of business. A mean cost figure is derived based on a series of unit costs. For each company, the number of units is multiplied by the average unit cost, which, in turn, is compared with that of all the other companies. If total expenses are more than 100 percent of the standard, it indicates a less than average efficiency of operations, negatively affecting the profitability index. If they are less than 100 percent, it indicates a greater than average efficiency positively affecting the index.
Weiss' liquidity index compares: 1) the company's liquid assets; 2) illiquid assets; 3) cash flows to its potential liquidity needs. The following are the subcomponents of each of these components:

- Liquid assets include cash and marketable securities, such as bonds with maturities of less than one year, publicly traded bonds of investment grade and common or preferred stock.
- Illiquid assets include items such as real estate, mortgages and investments in affiliates.
- Cash flow items include premiums and investment income less benefits and other expenses.
- Subcomponents affecting potential liquidity needs include:
- Liability for interest sensitive products (e.g. GICs, deferred annuities and other deposit funds), depending on cash-out provisions;
- The company's surrender experience;
- Market value adjustments; and • Surrender fees as disincentives for disintermediation.

The spread of risk factors utilized by Weiss include: size of investment portfolio; distribution of net premium and deposit funds by line of business; number of policies and contracts in force; and retention limits on ordinary and group life and use of reinsurance. Sources of earnings/capital include: operations (retained risk); reinsurance; investment earnings; realized capital gains; unrealized capital gains; capital infusions; paper adjustments (changes in MSVR, reserve valuation basis, etc.); and appropriateness of dividend levels (policy and stock).

Weiss' investment safety index utilizes risk and liquidity calculations separate from those used in the risk-adjusted capital ratios. Weiss' model considers investment yields, bond default rates, mortgage non-performance rates and portfolio diversification. The process evaluates the relative risks in each investment category and considers these in relation to a company's resources for dealing with them. Exceptional values are noted and analyzed to determine its relevance to a company's financial strength.

Weiss does not allow subjective judgments to alter a factual interpretation of the data. However, there are factors which other raters might treat as qualitative which are quantified in Weiss' system. For example, the New York Regulation 126 filing is analyzed in terms of the severity of the underlying assumptions used and the results of the scenario testing in terms of their impact on profits and capitalization. These are then carried over to the interest-rate risk factors in the risk-adjusted capital equation and other equations.

Another example is where the nature of the policy-loan provisions in each company's contracts is quantified in the risk factor associated with policy loans in the risk-adjusted capital calculation. Also, the impact of mergers, acquisitions and other special historical circumstances on mechanical ratios are factored out with filters tailored to the particular situation and then used for all companies falling into a similar category.

Weiss also measures the quality of management through quantitative analysis of historical data on past performance. Areas evaluated include: cost control skills; bond portfolio management skills; mortgage portfolio management skills; asset-liability management skills; and profitability management skills as measured by current and recent trends.

Rating Classifications and Distribution: In Weiss' view, the rating of an insurer's financial health should reflect the probability of that company meeting claims in the future as well as its probability of insolvency. Its objective is to place companies in a risk-class that accurately describes the likelihood of insolvency.
Weiss' basic rating scale ranges from A to F with "+" and "-" modifiers. A "+" sign indicates that, with new data, there is a modest possibility that this company could be upgraded. The A+ rating is an exception since no higher grade exists. A "-" sign indicates that, with new data, there is a modest possibility that the company could be downgraded. In addition, companies with less than $25 million in capital and surplus are designated with an “S” in front of their alphabetical rating. The “S” is simply a reminder that consumers may want to limit the size of their policy with this company so that the policy's maximum benefits do not exceed one percent of the company's capital and surplus. Also, companies receive an unrated classification U if: 1) total assets are less than $1 million; 2) premium income for the current year is less than $100,000; 3) the company functions almost exclusively as a holding company rather than as an underwriter. Weiss' basic ratings are listed below with their definitions.

> **A Excellent**: This company offers excellent financial security. It has maintained a conservative stance in its investment strategies, business operations and underwriting commitments. While the financial position of any company is subject to change, Weiss believes that this company has the resources necessary to deal with severe economic conditions.
>
> **B Good**: This company offers good financial security and has the resources to deal with a variety of adverse economic conditions. However, in the event of a severe recession or major financial crisis, Weiss feels that this assessment should be reviewed to verify that the firm is maintaining adequate financial strength. Carriers with a rating of B+ or higher, are included on Weiss' recommended list of companies.
>
> **C Fair**: This company offers fair financial security and is currently stable. But, during an economic downturn or other financial pressures, Weiss feels that it may encounter difficulties in maintaining its financial stability.

D Weak: This company currently demonstrates what Weiss considers to be significant weaknesses that could negatively impact policy holders. In an unfavorable economic environment, these weaknesses could be magnified.

E Very Weak: This company demonstrates what Weiss considers to be significant weaknesses and has also failed some of the basic tests used to identify fiscal stability. Therefore, even in a favorable economic environment, it is Weiss' opinion that policy holders could incur significant risks.

F Failed: Company is under the supervision of state insurance commissioners. The distribution of Weiss' ratings tends to be more bell-shaped with more insurers receiving average or below average ratings than assigned by other raters. A recent sample distribution of Weiss' ratings showed that of the 1,470 insurers receiving a letter grade, only 3.8 percent received an A grade and only 15.2 percent received a B grade. Of the rated insurers, 48.2 percent received a C grade and 32.8 percent received less than a C rating.

Dissemination of Rating Information: Consumers and agents are able to obtain a verbal rating over the telephone from Weiss for a charge. Consumers also can order an Insurance Safety Directory issued quarterly for all life and health insurance companies. The Directory includes key financial data and ratios for each company and a list of recommended companies with a rating of B+ or higher.

SUMMARY ON RATING SERVICES

There is a good deal of similarity among the rating agencies in terms of their basic objectives and approaches in evaluating the financial strengths of insurers. Their essential objective is to assess and offer an opinion as to the ability of an insurer to meet its obligations to policy holders. With the exception of S&P's qualified solvency ratings and the Weiss' safety ratings, the raters utilize both qualitative and quantitative analysis, apply certain basic principles, and follow similar rating processes. At the same time, there are differences among the raters, and they sometimes issue different rating opinions of the same insurers.

Rating the financial strength of an insurer is inherently a complex process, and there is considerable opportunity for variation. In terms of quantitative analysis, raters differ with respect to the specific financial ratios used; adjustments to data or ratios to reflect reserve adequacy, reinsurance quality, investment quality, ownership structures and other factors; the weights or significance attached to different financial ratios; and ultimately the way in which quantitative information is utilized in an insurer's overall evaluation.

Qualitative analysis provides even greater opportunity for different evaluations among the raters. Assessing the implication of qualitative factors for a company's financial strength, particularly over a long time horizon, inherently involves a considerable amount of subjective judgment. That subjectivity inevitably can result in at least marginally and sometimes significantly different rating conclusions.

Rating opinions are also affected by somewhat different rating philosophies. The securities rating firms essentially assess the risk that an insurer will not be able to meet its obligations to policy holders. Weiss also assesses an insurer's risk to policy holders but bases its assessment on more pessimistic economic scenarios than other raters. Alternatively, A.M. Best places greater emphasis on prevention than detection of insolvencies. For that reason, Best may exhibit greater patience than other raters in allowing a company to resolve its problems before downgrading it.

Insurance company ratings which are based strictly on statistical analysis -- S&P's qualified solvency ratings and Weiss Research's safety ratings -- fit into a special category. The primary advantages of quantitative ratings are that they cost less to perform and do not require the insurers being rated to cooperate. The agencies that issue quantitative ratings contend that they expand the availability of unbiased information to consumers.

Critics complain that quantitative ratings do not consider various qualitative factors that could explain adverse statistical results. Weiss responds that its approach avoids influence by company management to reach a more favorable rating determination than what the company's actual results suggest. However, in theory, qualitative considerations could also result in a less favorable rating. Indeed, it is difficult to argue with the fact that quantitative ratings are inherently more limited than ratings that consider qualitative information as well as quantitative information.

From a public interest standpoint, the issue boils down to whether the benefits gained from having additional rating opinions available, albeit statistically based, outweigh any costs that inure from their limitations. This analysis did not evaluate which rating philosophy or methodology was better or worse. Each rater offers support for its particular approach.

We also did not attempt to assess the accuracy of ratings by looking retrospectively at how failed insurers had been graded by different raters prior to the insurer’s failure. Ideally, such an assessment would consider accuracy in identifying financially strong insurers, as well as financially weak insurers. This is easier said than done because the fact that a low rated insurer has not failed does not necessarily mean that the low rating is not justified or that the insurer will not ultimately fail.

The emergence of additional raters during the 1980s responded to a perceived demand for more information and alternative opinions about insurers' financial strength. There seems to be fairly unanimous agreement that the availability of multiple rating opinions benefits consumers, even if there is disagreement about how these opinions should be formulated.

There are also different opinions about the ability of the users of rating opinions to evaluate the validity of those opinions and to sort good methods from bad ones. Some believe that regulators should intervene to prevent the supply of misinformation while others would prefer to rely on the market to sort good information from bad information.

RATING CHANGES

Agents, however, should, always be prepared for new regulatory environments coupled with diminished profits and the need for rating agencies to clamp down. Ultimately, this will affect ratings. While there are no wide scale insolvencies anticipated, deteriorating conditions eventually affect client confidence.

Marketing products and services in the face of reduced ratings will test agent due diligence and company selection skills beyond any previous limits. Be careful, back up your reasons for moving clients from one insurer to another, especially if the new insurer ratings' decline. In a period following major company failures it is also logical that the rating agencies will emerge with new, tighter criteria. They must also adapt to changing regulatory laws and formulas. Needless to say, major changes can occur at any time.

A preview of the intensity and breadth of change possible took place in July 1993 when A.M. Best shocked the insurance world by downgrading over half of the life companies who previously held A+ or A++ ratings to A. Before this, in late 1992, Best added six new letter ratings (A++, B++, C++, D, E and F). This increased the ratings of this firm from 9 to 15. It also brought to light the huge differentiation the company anticipates in company ratings. Further, it could be an indication that the company will no longer be timid in swiftly downgrading a company.

In an article, Best explained its rating modifications: "The purpose of these changes was to enhance the usefulness and clarity of our rating system. More important than the structural changes to Best's rating classification has been the continuing evolution of our analytical review. Specifically, qualitative considerations have become increasingly important in Best's rating system".

Some feel that the Best downgrades are tied to size of company. One company's analysis showed that 77 percent of the 71 companies adjusted downward had assets less than $600 million. Best contends that its rating framework is the same for all companies, regardless of size. They do admit, however, that there are advantages to size in certain lines of business.

According to the company administrative capabilities, technological advantages, lower unit costs and management depth can provide competitive strengths that contribute to market penetration and presence difficult to achieve in highly competitive businesses on a relatively small scale. Though such advantages may be reflected in rating assignments, smaller companies that remain highly focused and maintain sustainable and defensible strengths also fare favorably in Best's rating assignments.

Other rating services will also recognize the need to adapt their solvency formulas. In the past, some of these companies, namely Standard & Poors and Weiss, have based their analyses primarily on quantitative issues such as the insurer's claims paying ability based on statistics generated from statutory filings with individual state insurance departments or the National Association of Insurance Commissioners.

With new risks of regulatory violations, competition from new entrants, banks, thrifts, etc, and the delicate line insurers must walk between solvency and profit, it is likely these agencies will add fresh information to modify their approach. Few raters, with the exception of Moody's, have focused on the breadth of such issues. This is likely to change in the years ahead with the inevitable result being lower ratings.

Experts believe that one financial signpost to watch is the variation in a company's rating or a frequency in downward ratings. If an insurer's rating varies widely between rating companies, this could be concern.

Industry Benchmark Tools

In recent years, the industry has experienced a small taste of the new regulatory "bite". Despite huge insurer losses from hurricane and Midwest flood claims, regulators in these states prohibited major rate hikes and required companies to continue providing coverage. In Florida, consumer outcries prompted the state legislature to initiate a moratorium on "non-renewals" and limit annual rate increases to five percent when an increase of 20 percent is needed to recoup from hurricane losses.

The liquidity problems of life insurers are also a definite target for regulators. So great is the pressure and so many are the proposals that life companies are totally consumed with restructuring for

regulatory solvency to the detriment, some say, of passing on investment opportunities that could mean substantial earnings in years ahead. The management of profitability under these conditions runs a clear second to solvency issues. This could place life companies at a competitive disadvantage to banks and other financial services industries, where solvency issues have improved and profitability is again the first priority.

Risked Based Capital

Risk Based Capital is the creation of the National Association of Insurance Commissioners. Since its inception, the National Association of Insurance Commissioners has strived to create a "national regulatory system" by the passage of "model acts", or policies designed to standardize accounting and solvency methods from state to state.

Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners. The National Association of Insurance Commissioners can be considered a logical conduit for national regulation, since its members are the insurance commissioners of each state and at present, the authority of states to regulate the insurance industry is allocated to the states under the 1945 McCarran-Ferguson Act.

Risk Based Capital defines acceptable levels of risk that insurance companies may incur with regards to their assets, insurance products, investments and other business operations. Insurers will be required, at the request of each state insurance department, to annually report and fill out Risk Based Capital forms created by the National Association of Insurance Commissioners.

Formulas, under Risk Based Capital, will test capitalization thresholds that insurers must maintain to avoid regulatory action; recalculate how reserves are used; reduce capitalization required for ownership of affiliated alien insurers and non-insurance assets; and allow single state insurers to qualify for exemption from reinsurance capitalization if their reinsurance doesn't exceed five percent of total business written.

The Risked Based Capital system will set minimum surplus capital amounts that companies must meet to support underwriting and other business activities. Because the standards will be different for each company, the guidelines run counter to existing state-by-state regulations that require one minimum capitalization require. Insurers reporting Risk Based Capital levels of say less than 70 percent to 100 percent may be subject to strict regulatory control.

Scores from 100 percent to 150 percent might be issued regulatory orders requiring specific action to cure deficiencies. Higher scores might receive regulatory warnings and corrective action stipulations. Attaining 250 percent or more, would relieve an insurer from any further Risk Based Capital requirements in a given year. It is clear that Risked Based Capital encourages certain classes of investment over others. For example, an asset-default test under Risked Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages.

Industry critics say that the C-1 surplus requirements alone could be far greater than all other categories of Risked Based Capital like mortality risk assumptions, interest rate risks and other

unexpected business risks. Many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings.

Despite these efforts, C-1-rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market continues soft. A Saloman Brothers Inc study of almost 500 insurance companies clarifies the problem. Financial reports for these insurers, the median level of surplus capital was found to be at 189 percent of their respective risked based capital levels. Even though, a majority of companies exceeded the 150 percent threshold--thus, not requiring regulatory correction—the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when risked based capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risked Based Capital ratios.

On the surface, Risk Based Capital seems to solve many regulatory concerns. Solvency rulings are standardized from state-to-state and specific action is mandated across the board. This would appear to be acceptable by insurance companies who could now predict regulatory response in any state. However, as we have seen, Risked Based Capital could also adversely affect financially sound companies simply because they own more real estate.

Risked based capital also scores low among insurers for another very important reason. Risk Based Capital Reports can be disclosed and misunderstood by the public, despite National Association of Insurance Commissioners' confidentiality promises. It is easy to realize that disclosure concerning a low scoring company could damage or cause a "run" on the insurer. The National Association of Insurance Commissioners feels it has adequately provided for confidentiality within the Risk Based Capital Act. Specifically, the Model prohibits anyone in the insurance industry from using Risk Based Capital data and analysis in any public statement.

There is even a provision recommending that state legislatures exempt Risk Based Capital information received from the National Association of Insurance Commissioners from state "freedom of information" laws. Insurers doubt that any such exemption from disclosure will suffice, since few states have adopted any exemption legislation, and there is history that pressure from public, political and judicial arenas ultimately leads to access by anyone for any reason. In fact, there may be reason for insurance company concern about disclosure of Risk Based Capital data.

Recently, there have been attempts to retrieve information similar to Risk Based Capital data by an insurance journalist/analyst using "freedom of information" statutes. Many states denied the requests for reports, called IRIS ratios (Insurance Regulatory Information System reports) since this data are considered confidential by state financial examiners. Yet, in some states, the same requests for information had mixed success via direct court action. In response, the National Association of Insurance Commissioners adopted a policy to withhold IRIS report information from states that could not assure confidentiality.

Once information is demanded and then delivered to state regulators it becomes potentially fair game under freedom of information statutes. In a similar vein, there is concern that federal political pressure to subpoena confidential records of an insurer would allow even greater access since federal "freedom of information" statutes are typically more liberal that individual states. Safeguards

proposed by the National Association of Insurance Commissioners and state regulators may help forestall public access, but it may be optimistic to think that a foolproof method to avoid disclosure is possible.

Troubled insurers may well brace themselves for the likelihood that data on their Risk Based Capital could make national news or influence their ratings. Some, in the industry, also feel that the Risk Based Capital rules are simply too restrictive, subjecting many of the best known insurers to immediate regulatory action and/or "bad press". This, in turn might lead to a "run on the bank" that could tip these insurers into worse condition. The concern of these parties is that the risk based capital system doesn't falsely identify adequate capitalized insurance companies and undercapitalized ones as being adequately capitalized. Too much is concerned with the type of investment, rather than its quality. Just how companies react to these guidelines remain to be seen. As mentioned, many life and health insurers have already changed their investment strategies to more favorably align with Risked Based Capital guidelines by selling their large scale real estate investments and junk bonds.

Solvency & Financial Enforcement Trust (Safe-T)

In the search for a solvency "cure", it is possible that simple is better. Nothing could be simpler than a proposal called "Solvency & Financial Enforcement Trust" or SAFE-T for short. SAFE-T is considered a simple, straightforward solution because it eliminates the complex formulas proposed by many other plans, such as the National Association of Insurance Commissioners "Risk Based Capital" plan. Developed years ago by State Farm for use by property/casualty companies, the SAFE-T method would require each insurer to fund a custodial account at an institution that is not related or affiliated with the insurer.

The funding of this account would be accomplished using real, liquid assets. The amount of assets in the account would be sufficient to cover loss reserves and loss adjustment expenses. To facilitate claim payments from an insolvent insurer, the guaranty fund for a particular state has, in essence, a lien against the SAFE-T trust account. The value of assets in the custodial account would be verified annually by a Certified Public Accountant along with a certification of loss reserves. More recent amendments to the proposal allow the insurer to retain all ownership rights to the assets in the custodial account, as well as the rights to sell and trade them, so long as any securities meet qualifying standards under the act.

Only cash, cash equivalents, publicly traded securities classified by the National Association of Insurance Commissioners as medium or high quality would be accepted. Also, an insurer could submit an approved letter of credit to meet assets requirements. The amount of this letter of credit, however, could not exceed 15 percent of the amount required to be on deposit in the SAFE-T account. Further, an insurer would be provided some leeway if the value of the assets in the account dropped during the year.

So long as assets maintained 80 percent of the required value, the insurer would not be required to add more assets in the middle of the year. If, however, the value drops below 80 percent of the required amount, the insurer must immediately respond with additional asset deposits or risk a "cease and desist" order restricting the company from writing any new business. Custodians of the SAFE-T accounts would be responsible for reporting to the respective insurance commissioners the activity and value of the insurer's account.

In the event insolvency was imminent, the SAFE-T account would be available to make prompt claims or to reimburse the state guaranty fund. The advantages of the Solvency & Financial Enforcement Trust are many. First, many of the standards, such as the use of Certified Public Accountants and certification of loss reserves, are already in place. This will enable easier set up and enforcement. Second, SAFE-T is based on the use of assets considered by many, including the National Association of Insurance Commissioners, to be the most valuable to an insurer's ability to meet its obligations to its policy holders. Third, the requirements of SAFE-T seem to align with the needs of state regulators looking for an improved "early warning" system that could be enforced without the need to apply complicated formulas and legal hoops. And, fourth, the number of insolvencies may be minimized, since liquid assets of the company will be controlled by the custodian.

In past cases, by the time an insurer faced insolvency, most of the liquid assets had already been sold, leaving less valuable and illiquid ones to the liquidator, state guaranty fund and policy owners.

The Compact Approach

Another approach to solvency regulation is to improve the existing state guaranty system. One proposal by the National Conference of Insurance Legislators seeks to provide a uniform set of standards for all state guaranty fund regulators. This would be accomplished by creating an interstate "compact" or agreement among all states to standardize the protection provided by guaranty funds, as well as procedures to rehabilitate and/or liquidate an insolvent insurer.

The idea of a "compact" between states is nothing new. Article 10 of the Constitution provides for a mechanism for states to make agreements among themselves in order that fair treatment of the citizens be served. This has resulted in over 100 interstate compacts over the years on issues like taxes, vehicle laws and crime.

There is no reason this wouldn't work to overhaul the current state guaranty systems which are riddled with loopholes, exclusions and diverse protection limits. It is common knowledge in the industry and among regulators that improvements to the system are needed, especially in the aftermath of public hearings presented to members of Congress in the early 90's. Significant weaknesses in the guaranty fund system were discussed, and the fear among industry leaders and regulators alike is that a lack of action to respond with corrective action may result in efforts to replace the state guaranty system with a federal mandate.

State fund problems aired in the public hearings include guaranty limits, insurer and policy owner residency and specific product exclusions. Guaranty fund limits vary widely between states. Some funds will only cover residents of their state, others will back anyone insured by a company that is domiciled in the state. Additional variations include service and product coverage. Some funds guarantee all annuities written by domiciled companies while others exclude variable type policies. Some cover HMOs and Blue Cross/Shield plans, while others do not.

The National Association of Insurance Commissioners developed "model acts" which it hoped most states would follow: The Post-Assessment Property and Liability Insurance Guaranty Association Model Act (1969) and the Life and Health Insurance Guaranty Association Model Act (1970). The property/casualty model sets maximum limits at $300,000 for any claim with unlimited coverage for workers' compensation. The life/health model includes maximum benefits of $100,000 in cash values of life, annuity and health contracts and $300,000 in death benefits.

The interstate "compact" proposed by the National Conference of Insurance Legislators could potentially smooth out the differences among states and bring about a set procedure for handling insurance company insolvencies. The proposal suggests this could be accomplished by creating a commission, called the Insurance Claimant Protection Commission, to coordinate the activities of all state funds participating in the compact and act as the receiver of insurers placed in rehabilitation or liquidation.

The commission would be comprised of the commissioner of each state. Each state would have one "member vote", as well as a designated number of "premium votes", based on the state's total premium volume. Any decision by the commission would require a majority of both member and premium votes. Commission meetings would be public, unless a majority of members agreed that subjects discussed would reveal trade secrets or confidential information.

Funding of the commission would be through assessments of insurance companies doing business in the compact states. Reports would be made annually to the governor and legislature of each state as well as the National Conference of Insurance Legislators. Regulations and statutes approved by the commission would be binding on all state funds in the compact. As an escape measure, each state's legislature could vote to reject a commission statute. If a majority of states follow suit, the specific regulation would have no force and effect on any compact participant.

Under the threat of federal intervention, it is likely that the interstate compact should attract major attention. Already, insurance departments of several states are amenable to working on a compact plan and the National Conference of Insurance Legislators is in process of contacting state legislators, policymakers and industry trade groups. The fact that the interstate compact was conceived by state legislators with technical assistance from one of the nation's top insurance law firms give it a greater chance of success than many other solvency proposals.

Federal/State Co-Regulation

On the heels of several large insolvencies, a flood of regulatory initiatives have emerged. Critics of the new proposals say there is no panacea for the problem of insolvencies. Even federal intervention will not bring an end to insolvencies, since they are inevitable in a free market. Then, too, the federal government does not have a stellar record in the area of efficiency and regulatory success. Others, however, believe that federal involvement in the regulation of insurance is necessary to industry stability and the centralization of authority. While there is cause to doubt this last proclamation, it is possible that some form of federal and state system of regulation will be attempted.

The Federal Insurance Solvency Act of 1992 is one such form. Under this act, a solvency commission is established to regulate all insurers. Insurance companies and reinsurers receive the equivalent of a "solvency certificate" which would permit them to do business anywhere in the United States. The bill also creates a protection or guaranty fund to cover any insolvency losses.

Some believe that a slightly different "two-tiered" system can work. Federally licensed companies could do business alongside state licensed insurers much like they do in the banking industry where some institutions are federally chartered while others operate solely under the jurisdiction of the state. Insurers, both large and small, could have the choice to be federal or state licensed and limits on guaranty funds could be standardized. Additionally, an insurer could and should be totally regulated by either the federal or state system, not partially regulated by both.

The advantages, of such a system, key on uniformity for the insurer wishing to do business on a nationwide scale. Policy owners would also know that guaranty fund limits are the same from state to state. One would wonder, however, if such a system would favor federally licensed companies where policy owners might feel a federally backed guaranty fund is safer than a state fund. It is suggested, then, that for a successful federal-state system to exist, competition must be eliminated.

That is why many industry regulators and players believe that a new, untried federal system is not practical. They argue that in place of scrapping state systems of regulation, a major restructuring of existing state guaranty funds and universal solvency rules would have greater value. Thus, proposals like Risk Based Capital, SAFE-T and the Interstate Compact must be seriously considered to "head off" federal intervention.

Model Investment Laws

The National Association of Insurance Commissioners has also made headlines for its Model Investment Laws. The purpose of these regulations is to prevent insurance companies from concentrating too much cash in too few types of assets. Critics feel the National Association of Insurance Commissioners' guidelines rely too heavily on classifying by type of investment and risk and setting percentage maximums.

National Catastrophe Fund

Although it may be years in the making, a National Catastrophe Fund is also being considered. During hearings before the Senate Commerce, Science and Transportation Committee, details indicate that this fund would reinsure existing companies to ease the impact of major disasters. A company with losses that exceeded 20 percent of its surplus would qualify for assistance. Because only regional and small companies are likely to collect from such a federal fund, the current thinking is that the amount of losses would not be large enough to seriously strain the fund.

State Catastrophe Funds

Regulators have and will be influential in convincing state legislatures to establish catastrophe funds. These funds may start out to be permanent solutions only to fizzle out within months or years after the disaster has struck. Current efforts include Hawaii and Florida, where major hurricanes have hit in the 1990s. In Hawaii, the state hurricane fund is the exclusive provider of hurricane insurance.

The programs are financed through a variety of real estate fees, premium taxes and assessments. The systems functions as a reinsurer to companies writing within the catastrophe zone Florida's hurricane trust fund will reimburse insurers for 75 percent of their losses once claims surpass two times the amount of the company's annual premium. Financing of the program will be through surcharges on policies, a percentage of premiums written, emergency assessments and state guaranteed bonds.

Financial Solvency Analysis

There are as many theories as there are people analyzing insurance companies. Favorite ratios are:

Technical Analysis: A former insurance commissioner, Bruce Bunner, proposed five financial formulas producers could use themselves to test for carrier solvency. Bunner noted that agents and brokers are not expected to be experts in the financial analysis. "Nevertheless, a producer does have a moral response", said Bunner, "to perform reasonable due diligence procedures with respect to the financial credibility of insurance companies being used to underwrite clients' risks.

Bunner feels that financial ratios in and of themselves are not a panacea. They can, nevertheless, serve as guideposts to identify positive and negative financial trends and the comparative health and stability of a company within the industry. Further, "when the evidence clearly indicates that a company's financial condition is deteriorating, too many agents and brokers continue to place their customer's risk with the same company. When price alone is the only marketing consideration and the producer disregards emerging negative financial signals, the agent is doing an extreme disservice to his client, and as such, must morally share some culpability with company management when and ensuing financial debacle occurs."

Bunner's five ratios are simple to calculate and the necessary company financial data is readily available to the public in the annual statements on file at each state's department of insurance. The suggested formulas are: Gross premiums written to surplus; Two Year operating ratio; Surplus to admitted assets; Loss and expense reserves to surplus; and, The acid test.

Gross Premiums Written to Surplus: This is a variation on the National Association of Insurance Commissioner's IRIS test ratio (Insurance Regulatory Information System) which compares net premiums written to surplus. The National Association of Insurance Commissioner's IRIS test guideline considers a result of 3 to 1 as acceptable. Bunner feels 2.5 to I as preferable. Further, he believes that the IRIS test ratio should be expanded to compare gross premiums written to surplus rather than net premiums written to surplus.

Gross premiums written in excess of 4 to 1 surplus should be considered unacceptable. Further, Bunner feels that the relationship of gross written premiums to surplus is more important because the National Association of Insurance Commissioners IRIS test fails to consider the effect of disproportionate reinsurance activity. Reinsurance transactions, therefore, can grossly distort results.

To account for reinsurance activity, Bunner suggests that a ratio of 4 to I for gross premiums written to surplus allows for up to 25 percent reinsurance premium credit to achieve the 3 to 1 National Association of Insurance Commissioner ratio benchmark. If a company has to reinsure more than 25 percent of its direct premium business, Bunner suggests an agent ask why, and then verify the financial security of the applicable reinsurance company or companies. "I would question closely", says Bunner, "companies that are in effect using reinsurance to broker significant amounts of direct business (25 percent or more of direct premiums) and, particularly if the direct business is being channeled to the non- admitted market.

Two Year Operating Ratio: The two year operating ratio is an IRIS test that is basically an expansion of the combined loss and expense ratio where the ratio of the investment income to premiums earned is deducted from the combined ratio. Using financial figures for two years helps to level possible aberrations. Bunner says, "we traditionally have expected the two year operating ratio to be a result of 100 or less. A result in excess of 100 suggests that the company is not achieving an underwriting profit, but relying on investment income to offset underwriting losses and to achieve a reasonable return on equity".

A quick calculation that can be done on a quarterly basis to achieve the same conclusion is to compare net income (exclusive of realized gains and losses) to prior years surplus. A result of less than 10 percent generally may be indicative of potential problems. A return on statutory equity of 10 percent or less hardly justifies the opportunity cost of the company's investment in statutory surplus. If the stockholder(s) are not willing to insist on an adequate return on equity, you may want to make some further inquiries.

For both these tests, realized investment gains and losses should be excluded from investment income. This is a modification of the IRIS test which Bunner believes is appropriate because such gains and losses are non-recurring transactions and largely discretionary. From time to time, companies have been known to selectively sell appreciated assets to improve the appearance of operating results.

Surplus to Admitted Assets: Surplus to admitted assets generally exceed 25 percent for most insurance companies. A ratio of less than 20 percent for an individual insurance company should be considered questionable. According to Bunner, "surplus provides a cushion for absorbing potential above-average losses". As discussed in the next section, deficiency in loss reserves usually carries over into higher multiples when related to surplus.

If the company under evaluation is a member of a holding company system and fails this surplus ratio, Bunner suggests an agent should not be dissuaded by any arguments from management that the company's surplus is reinforced by the adequacy of the surplus of the parent or affiliated companies. Bunner states, "I strongly believe that every company granted a charter should be financially independent and its economic viability should not be dependent on other related entities."

Reserves to Surplus: The ratio of loss and loss expense reserves to surplus is not an IRIS test. However, Bunner thinks that ratio deserves more consideration by the National Association of Insurance Commissioners because of the extreme leveraging that is now more common in the insurance industry. It would be preferable if this ratio could also be calculated on a gross basis (before reinsurance) rather than on a net basis (after reinsurance). Bunner believes that a net loss and loss expenses reserves to surplus should not exceed 3 to I.

The Acid Test: This is Bunner's own formula for quickly evaluating company liquidity or as certain what he refers to as "hard surplus". Obviously, the formula can be refilled but it does adjust for some of the weaknesses of statutory accounting. For this test, subtract from surplus the home office building(s), computer equipment, and any non-insurance receivables and other non-insurance assets that are reported as admitted assets by the company.

This adjustment separates from surplus that part of surplus which is basically applicable to the operating assets of the company. From this adjusted surplus amount subtract any affiliated investments and advances; unrealized losses on investments in bonds and preferred stocks; and any contribution certificates, surplus notes and subordinated debentures; and add back the surplus appropriation for accumulated excess Schedule p reserves.

The adjustment for affiliated investments and advances is to remove from surplus the effect of any pyramiding of assets which in extreme situations often contributes to insurer solvency. Unrealized losses on bonds and preferred stocks are typically disclosed in report supplements included with a company's annual statement on file at state insurance departments. Bunner believes that all investments held by an insurer should be reported at their current value.

"The current accounting model", he says, "using amortized costs for fixed yield securities is too forgiving to company management. Statutory accounting obscures the effect of lost investment opportunities and encourages investment decisions (particularly investment holds or sell decisions) to be driving by accounting rather than economic conditions. Once all the adjustments above have been made, a surplus of less than zero. He suggests that the company may have liquidity -problem or be over leveraged.

In closing, Bunner suggests that the failure of anyone or more than one of these tests is not necessarily indicative of a company financial problem. Further, these tests do not adequately consider some complex financial issues associated with reinsurance, security of letters of credits, off balance sheet commitments and issues related to specialty companies writing insurance products as earthquake, professional malpractice, financial guarantee bonds and so forth. However, prolonged failure of any of these tests might suggest that company management is choosing to operate outside the boundaries of sound financial guidelines and should be suspect.

Non-Technical Analysis

Reinsurance: Reinsurance is an effective tool for spreading risk and expanding capacity in the insurance marketplace. The strength of the guarantees backing the primary policy, however, is only as strong as the financial strength of the reinsurer. Abuses have occurred where the levels of reinsurance have been too high, the quality poor and the controls nonexistent. Industry analysts suggest that the total amount of reinsurance should not exceed 0.5 to 1.3 times a company's surplus.

Agents should also be concerned about foreign reinsurance since the U.S. regulation and control is difficult. See how much of the foreign reinsurer's assets are held in the United States. Ask if the reinsurer has directly guaranteed the ceding company or using bank letters of credit for this purpose. These credit letters have not been effective guarantees in the past.

Under terms of the ceding contracts, can the reinsurance be "retro-ceded" or assigned by another reinsurance company: it is possible to have layers of reinsurance which could create difficult legal maneuvering during liquidation. Does the ceding contract have a "cut-through" clause which allows the reinsurer to pay deficient policyowners or insureds direct, rather than to the liquidator? Is the insurer writing a significant amount of new business that may require costly amounts of first-year reinsurance?

First-Year Reinsurance: The first year that an insurance policy goes on the "books", the insurance company suffers a loss. This is attributed to laws related to the accounting valuation of the policy and the high costs or expenses paid in the first year (commissions, etc.). A loss to an insurer, is also reduces a company's surplus. A strain on surplus can create all kinds of problems with regulators and lenders, so insurance companies go to great lengths to shore up their surplus from the losses of first year policies.

This may be accomplished by raising additional capital or through some form of financing. More often than not, however, an insurance company will simply call up the local reinsurance company and obtain surplus relief reinsurance. Once in place, surplus reinsurance provides the ceding company (the insurer who uses the reinsurance funds) with assets or reserve credits which improve the

insurers earnings and surplus position. The major difference between using reinsurance to cover first year losses and a loan is how the transaction is reported.

When an insurer obtains a loan, the accountant must record a liability. Reinsurance for surplus relief, however, is not considered a liability under statutory accounting because the repayment is tied to future profits of the policy or policies being reinsured. Collateral for the reinsurance, in essence, is future profits. Thus, reinsurers run substantial risks when the ceding company cannot pay.

The fee or interest for providing the reinsurance is typically from 1 percent to 5 percent of the amount provided. Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners for implementation starting in 1994.

The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows: "If the reinsurance agreement is entered into for the principal purpose of providing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged."

Restructured Loans: What percent of an insurer's non-performing or under-performing real estate projects have been "restructured"(sold and self-financed to a new owner at favorable terms to eliminate a "drag" on surplus)?

Size of Company: Statistically, fewer insurance failures have hit companies with assets greater than $50 million. It is thought that larger companies have more diverse product lines, big sales forces, and better management talent.

Lines of Business: An agent may not have many choices over the company he writes, e.g., worker's comp coverage can only be secured with a carrier willing to write worker's comp. It has been suggested, however, that agents may consider evaluating multi-line companies to determine if one of the lines is weak enough to "down-drag" a profitable line.

An example could be a life company that also writes health insurance as a direct line or business or by affiliation. If health carriers become threatened under a new national health care proposal, it could spell trouble for an insurer's health line, which can affect all lines of business written. Of course, this is not to say that a multi-line carrier cannot be profitable and solvent.

State Admitted: Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries. Some states will also divulge the rank of an insurer by the number of complaints per premium volume.

Mergers: Insurance ratings are sacred territory. A rating drop against Mutual Benefit Life triggered a run on that insurer which caused its conservatorship. This news and the overall crisis of confidence surrounding the insurance industry has prompted insurers to consider many options to shore up these ratings.

One option is the merger. The combining of companies can be critical to retaining policyholders, attracting new customers and maintaining investment capital sources. Some experts believe that consolidations in the insurance industry will become more commonplace in the future. One source estimated that the current number of life insurance companies--estimated at 2,000--will merge down to an eventual 200 insurers sometime in the future.

Parent & Holding Company Affiliation: Who or what kind of company owns the insurer that is considered. Is the parent sufficiently solvent that it will not recruit or siphon funds from the insurer? In a like manner, does the insurer own an affiliate that may likely need capital infusion from the insurer? Has the agent's insurer recently created an affiliate and are the assets in this affiliate some of the non-performing or under-performing investments of the original insurer?

Is a merger in the offing that might mingle your client's A-rated company with a larger B+ company? In what partnerships or joint ventures does the insurer participate? Do these entities own problem real estate properties of the original insurer? Has the insurer invested in other insurance companies and have those companies, in turn, invested back in the original insurer or one of its affiliates?

Name recognition can go a long way in giving a client a high level of comfort. But abuses do occur. For example, Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "noninsurance" parent. Further, not all abuses have been on the side of the parent. Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes including sale and leaseback arrangements and the securitization of future revenues.

GAAP Bending (Generally Accepted Accounting Principles): Even before the National Association of Insurance Commissioners' risked based capital proposal, insurance companies were feeling regulatory heat for a fairly common practice involving underperforming and nonperforming real estate. In the past, insurance companies have simply carried the value of their real estate at its historical cost.

Yet, it makes little sense to use this approach when that property is not economically viable and is worthless. This is especially true in the early 1990's where the fair market value of commercial property have decline rapidly and perhaps below historical cost. However, showing lower valuations would mean that insurers might develop capital deficiencies or incur substantial write downs.

Either situation is hard to apply. Now, new GAAP (Generally Accepted Accounting Principles) rules are being used by auditors which require foreclosed property or underperforming real estate to be valued at its current fair market value. Insurers must decide whether to continue holding an asset until the economy rebounds or risk further deterioration. Further, now that risked based capital is on their doorstep, holding nonperforming real estate may require companies to set aside additional reserves. In the past, if regulators started complaining, insurers would increase their capital, either from a parent company or through security offerings. While this would aid the insurer's liquidity, the original asset would remain on the books, perhaps at a deep discount.

Asset Spin-Off's: Insurer balance sheets can easily get out of line if they hold underperforming or nonperforming real estate. As mentioned above, new GAAP write down rules would require a valuation of this real estate at its current fair market value, which may be extremely depressed. To help "clean-up" their balance sheets and possibly avoid strict risked based capital requirements,

some insurers transfer or "spin off' the foreclosed or underperforming asset to a new entity which they create.

This entity sells bonds or stock to the general public to buy the problem asset(s) from the insurer. Since this is considered a sale, the asset gets off the books. The need to set aside reserves and meet GAAP rules is eased. And, company ratings are maintained. In all fairness to insurers, what appears to be a deception is often a sound business strategy to "hold" an asset that is not performing today but is expected to rebound when the economy improves.

So long as this can be accomplished and not hamper current operations, the insurer may be making a smart move since significant appreciation in the asset down the road could later improve the company's balance sheet by leaps and bounds. Also, "spin-offs" are not without their risks. There is the cash drain of starting a new entity, the deep discount of the sale and the possibility of a taxable event.

Collateralized Mortgage Obligations & Derivatives: In the past, when insurance companies wanted higher investment yields they turned to real estate and non-investment grade bonds. New risked based capital rules, however, make these types of investments difficult to "book". Insurers, however, have found ways to still participate in the yield of these investments without owning the actual product: collateralized mortgage and derivatives.

In simplest terms, collateralized mortgage obligations and derivative are like stock certificates backed by mortgages or bonds. The "slant", however, is that they are owned by a trust and then sliced into pieces of various maturities consisting of principal and interest payments. They are also further divided into issue classes called "tranches".

The first principal payment, for example, would go to Tranch 1; and so on. Tranch 2 might be "interest only" strips. Investors will jockey for particular tranches based on their rate of interest, their individual requirements and their outlook on where interest rates are going. Investments in the junior tranches offer significant yields, yet come with the risk of prepayment. Senior tranches generally minimize market risks since cash flows are more predictable. Suffice to say, CMO's and derivatives are highly sophisticated, higher risk investments that require sophisticated monitoring and significant hedging capability.

Tax Angles: Regulators and accounting practices appear to be getting stiffer for insurance companies. One thing the industry can still count on is certain tax advantages. In essence, losses from insurance operations can be used to lower taxes elsewhere (such as capital gains from the sale of bonds or real estate). Multiline companies can use losses from property and casualty claims to offset profits from health and life insurance divisions.

Surprisingly, companies can sometime take a percentage of their losses as a "tax credit" and write it up as an asset on the theory that the tax credit will be worth something to them in a profitable year. This practice is acceptable as long as the company can show beyond all doubt that it will be able to use the credit sometime in the future. Critics, feel that the tax credits are actually "paper profits" which can hardly be used to pay claims.

In periods where insurers are posting major losses--such as the mid 1980's and early 1990's--tax credits such as these may account for up to 70 percent of a firms operating income. How much of an insurer's operating income consists of tax credits generated from claim losses or guaranty fund? How

much of an insurer's operating income comes from large capital gains earned from the "bulk sale" of longstanding bonds or real estate?

Restructuring Loans & Partnership Deals: The last thing an insurer wants from its books is foreclosed or underperforming real estate. New risked based capital and GAAP accounting standards deal harshly with this type of asset. This is exactly the type of asset, however, that many insurers are "knee-deep" in handling, especially on the heels of big real estate purchases in the late 1980's with money raised from guaranteed investment contracts (GIC's).

A way to alleviate the underperforming properties is to convert them to new loans - essentially refinance them for the owners at new, easier to handle payments – or restructure the existing loans by temporarily dropping the payment. It is also interesting to note that many insurance companies own problem properties and assets that regulators do not see because they are owned through a partnership between the insurer and a joint venture entity.

Liability Adjustments: Reducing liabilities is always desirable since surplus will be enhanced. Some companies make small adjustments to their liabilities to make them appear smaller. One such adjustment can be accomplished by deducting the surrender charges policyholders would pay if they cashed their policies in early. Companies have been known to take this deduction knowing full well that not all policyholders will require early withdrawals or full surrenders of their policies. Some insurance regulators still allow this accounting method.

Cash/Stock Swaps: When things get tight, some insurance companies invest in each other or among their subsidiaries using a system of complicated cash and stock swaps.

Selling Loss Reserves: Under pressure to improve earnings insurers have used the somewhat questionable technique of "selling loss reserves". How does an insurer sell losses? Generally, it involves paying another insurer now for its promise to pay certain claims in the future.

A few years back, for example, a carrier passed the liability for an estimated $80 million of unpaid medical malpractice insurance claims to another carrier in return for an agreement to eventually pay those claims. The buying carrier received a steep discount on the claims for a profit of approximately $22 million. The selling carrier relieved itself of $80 million in liability. Reinsurers are also big buyers of loss reserves. Critics say its an accounting gimmick. Industry spokesmen claim it is merely a method of transferring risk.

Insurer Insolvency

When a state determines that an insurer is in trouble, the insurance commissioner usually files an application to the court. The court petitions the insurance company to show cause why the company should not be placed in rehabilitation or liquidation. Once a company is placed under supervision, an injunction is issued to restrain the insurer, its officers, agents and others from any disposition of property without court approval.

Liquidation is the more severe condition where the insurance commissioner must take title to the insurer's assets and use them to pay creditors and policy owners. Rehabilitation, on the other hand, allows for a restructuring of the insurer under the guidance of the commissioner. Unless the condition is extremely severe, companies are usually started in rehabilitation. If it is later determined that a

restructuring will still not revive the insurer, a liquidation is ordered. If an insurer is liquidated, all policy owners and other potential claimants must be informed and permitted to file a proof of claim with the insolvent estate.

These claims will then be evaluated and a value established. Recent failures have demonstrated that claim values can be less than the amount due the policy holder. Under these conditions, a policy owner can file an appeal and seek a court decision before the actual liquidation of the company occurs. In order to protect the overall insurer estate, there are time limitations for filing these appeals. Once all appropriate values are determined, the assets of the insurer will be distributed under a statutory procedure. This process requires that certain priority lien holders be paid in full, while others may divide what is left.

The typical liquidation order of priority is as follows:

1. Liquidation expenses and costs
2. Unpaid wages of employees of the insurer
3. Taxes
4. Policy holders, insureds and guaranty funds
5. Reinsurers and all other claims

If a reinsurer indemnifies a liquidating company, it is only required to pay to the liquidator the actual loss it indemnifies. In other words, the reinsurer can only be called upon to pay deficiencies up to the limit it has agreed, once the ceding company, the liquidating insurer, has made all possible payments. This provision, which appears in most reinsurance contracts, is called an insolvency clause.

The disadvantage of an insolvency clause is that policy owners, guaranty funds and other third-party claimants have no additional claim against reinsurance proceeds. An exception to this rule is where a cut through clause exists. A cut through endorsement would require a reinsurer to pay a loss or specified portion of a loss directly to the policy owner or insureds when an insolvency or another specific event occurs. General creditors and other third party claimants could be excluded under a cut through endorsement.

The Need for a Safety Net

In any competitive environment, even one as intensively regulated as insurance, insolvencies will occur. The proper role of insurance regulation is to avoid financial failure if possible, detect it as soon as possible when it cannot be prevented, and act promptly to contain its size and impact once the insolvency is known. The vast majority of insurers failed because they priced their product too cheaply. They neglected to underwrite adequately by identifying the nature and extent of the insured risk.

In almost all these cases, the signals were disproportionate increases in premiums written; entry into new and exotic lines of business; risky investments; precipitous drops in surplus; reinsurance to temporarily bolster surplus; overly generous dividends to parent companies; and low claim reserves. A Best's Insolvency Study confirms this conclusion.

Of all property/casualty insolvencies since 1969, 28% were caused by inadequate pricing, which resulted in inadequate loss reserves; 21% by rapid growth; 10% by alleged fraud; 10% by overstated

assets; 9% by significant change in business; 7% by reinsurance failure; 6% by catastrophic losses; and 9% by "miscellaneous".

Some believe that inadequate pricing and deficient loss reserves, rapid growth, overstated assets, and significant change in business should have been detected through regular examinations, market conduct exams, holding company reports, annual statements and CPA audited annual reports of non-insurers, as well as by just listening to street talk. It is true that a few insurers were known by general industry discussion to be in trouble long before regulators took action.

Reinsurance failure as a cause of insolvency can be prevented by exercise of the existing regulatory authority by the ceding insurer's domestic commissioners as to the granting or denial of credit for unauthorized reinsurance and by the regulation of the solvency of licensed reinsurers by their domestic commissioners. Moreover, "reinsurance failure" as it impacted on some ceding insurers can more appropriately be characterized as "poor management" by the ceding insurer because, as Best's stated, they "purchased the least expensive reinsurance protection without sufficient regard to the financial strength of the reinsurer."

Many insolvencies attributed to "reinsurance failure" are almost always the result of other causes, with reinsurance only becoming a factor after the ceding insurer has been declared insolvent, when the reinsurer disclaims its coverage, alleging fraud.

The biggest states with larger department funding were those with the most insurer failures. Best also confirms this failure of the regulatory giants. Of the 372 property-casualty insurance insolvencies between 1969 and 1990, 187, or 50%, occurred in six states. These states, that domiciled only 34% of the insurers during the period, were Texas (47 insolvencies); California (35 insolvencies); Pennsylvania (35 insolvencies); New York (30 insolvencies); Illinois (22 insolvencies); and Florida (18 insolvencies).
Of these six states, four, California, New York, Texas and Florida, accounted for 48% of the $429 million budgeted for all 50 state insurance departments (plus those of the District of Columbia and Puerto Rico), and the other two highest insolvency states, Illinois and Pennsylvania, with another 5.6%, were in the top 9 states with the highest regulatory budgets. It is unlikely that more money to these six states would have avoided any insolvencies.

Why do states so rich in funding and expertise permit so many large insolvencies to occur? Why don't they catch them sooner? One school of thought blames the political nature of insurance regulation and the very existence of guaranty funds. As insurance has become a more public factor in our economy, insurance regulators have found themselves in an increasingly political arena. They have permitted or been forced to allow their focus to shift from the primary role of the regulator to what has become the more visible issue of pricing.

Rate and policy form approval, particularly for commercial insurance where the buyer neither needs nor wants this layer of "protection", drains essential regulatory resources that could better be directed to the solvency of insurers. Examinations of insurers that focus on trivia as much as essentials and that take up to three or more years to complete, being outdated by the time they are released, no longer perform the investigatory and preventive role that used to spot trouble before it became fatal. Like everyone, insurance commissioners do not like to admit failure, and many commissioners and their staff view the insolvency of a domiciled insurer as a personal and institutional failure.

Regulators welcome promises of cash infusion, assertions of improved payout patterns, claims of better quality of new business and investments, and the assertion that "things can't get any worse," anything to avoid or delay the admission that, despite their best efforts, a failure occurred. Unfortunately, in too many cases these promises are unrealistic and are never fulfilled, and, during the period of regulatory indulgence, the insurer's financial condition rapidly deteriorates, new policy holders pay for coverage they will never receive, and, as a result, other insurers and taxpayers end up paying more to clean up the default. Although the insolvency most likely was predetermined years earlier when bad business was written below cost or unrealized investments were made, the situation worsens as new business is written at even less adequate prices in desperation to maintain liquidity.

State Guaranty Funds

The purpose of the state guaranty associations is to fully guaranty the reasonable expectations of the vast majority of individual policy and group insurance certificate holders. It is important to note that these associations do not exist to underwrite any and all promises, no matter how large or reckless. In essence, state guaranty associations have limitations.

Guaranty associations are created by state law "to protect policy owners, insureds, beneficiaries, annuitants, payees and assignees against losses, both in terms of paying claims and continuing coverage, which might otherwise occur due to an impairment or insolvency of an insurer." When an insurer becomes insolvent, it frequently exits the market with liabilities in excess of its assets.

To date, state legislators have used guaranty funds to shift most of the burden of the shortfall from the policy holders of the insolvent company back to insurers. Absent guaranty fund protection, the policy holders of the insolvent insurer would be forced to absorb the complete loss produced by the insolvent insurer. Guaranty funds provide policy holders and beneficiaries with an entity ready to absorb most of the losses left by
the insolvent insurer.

Guaranty funds are able to provide protection to policy holders by assessing surviving insurers for amounts necessary to pay the claims of the insolvent insurer. Essentially, these funds shift the burden of the shortfall from policy holders to surviving insurers. Managers of the surviving insurers must then allocate the assessment.

Groups that could be called upon to absorb the assessment include: equity holders, policy holders, employees, and taxpayers. Most states use premium tax credits to shift the shortfall to taxpayers. The assessment paid by insurers can be viewed as an interest free loan to the state by way of the guaranty fund. The loan is partially repaid in the form of tax credits and deductions. Federal taxpayers also receive part of the burden as assessed insurers deduct their assessments from taxable income.

The Liquidation Process: The liquidation process can be extremely involved and lengthy. This is the reason that guaranty funds were established. They are an advance payment system to pay off individuals and groups who would be devastated by the liquidation process. A claim against a state guaranty fund is typically limited to residents of that state.

Payments are limited to certain amounts, depending on the type of insurance purchased. Once a claim has been paid, the guaranty association becomes subrogated to the claimant's rights to further payments. Thus, a policy holder who collected from a state fund forfeits his claim rights against the insolvent insurance company. The guaranty associations are non-profit legal entities whose members

comprise all insurance companies licensed to write insurance or annuities in the state. Each association is governed by a board of directors approved by the state's insurance commissioner.

Exclusions: In general, guaranty acts exclude from coverage policies issued by entities that are not regulated under the standards applicable to legal reserve carriers. Insurance exchanges, assessment companies, fraternals, HMOs and, in many cases, Blue Cross and Blue Shield are commonly excluded.

The guaranty laws also commonly exclude from coverage policies or portions of policies under which the risk is borne by the policyholder or which are not guaranteed by the insurer. Variable accounts in some life policies or annuity contracts are examples. Significant variation does exist in the treatment of unallocated funding obligations (UFOs), including GICs, which are commonly purchased as pension plan assets on professional, sophisticated advice by pension plan trustees.

Limits of Protection: Most guaranty associations limit their protection to policyholders who are residents of their own state. (It does not matter where the policyowner's beneficiaries live.) The trend toward adopting such a residents-only provision follows a major amendment to NAIC's model guaranty act adopted in 1985.

Arizona, Virginia, West Virginia, Nevada, North Carolina and Oregon very recently amended their life-health guaranty laws to cover only their own residents. However, if the insolvent insurer's domiciliary state follows the NAIC model, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty act and the impaired company was not licensed there and the policyholder is not eligible for coverage there.

An example of such a situation would be a New York resident who owns a policy of the Executive Life Insurance Company, which is domiciled (chartered) in California. Since New York has a life-health guaranty association but the company was not licensed to do business there, New York residents will be covered by the California Life Insurance Guaranty Association. However, residents of a jurisdiction such as the District of Columbia which does not have a life-health insurance guaranty association would have no guaranty association protection, even though Executive Life was licensed there.

Other states, like Alabama, still follow an older model act and guaranty benefits of impaired or insolvent insurers domiciled in their own state, no matter where the policyholders live, and also cover their own residents who are policyholders of licensed companies domiciled in other states, unless coverage is provided by the state of domicile.

Dollar Limits: Typical payouts to policyholders who are victims of failed or financially strapped insurance companies might read as follows:

Life and Health Guaranty Funds

- Maximum death benefit $300,000
- Maximum cash value covered $100,000
- Maximum Annuities $100,000
- Maximum Health and Disability $100,000
- Maximum Aggregate Per Person $300,000

Property/Casualty Guaranty Funds

• Maximum Claim $300,000 - $500,000

Individuals who have several policies may have additional limits. For example, a person who owned a term life insurance for $500,000, a whole life policy with cash values of $150,000 and a single premium annuity with an accumulated value of $200,000, will collect only $300,000, the maximum aggregate limit per person regardless of how many policies.

The fact that these policies may be spread among three different insurers does not make any difference. There would still be a $300,000 maximum in most states. The same is true for property/casualty claims. Regardless of the number of policies or how they are distributed among different insurance companies, the maximum claim that can be paid by a state guaranty fund is fixed at between $300,000 and $500,000 per individual.

It is also interesting to note that limits of State Guaranty Funds are strictly limited to the basic coverage of the policy.

Triggers: Generally, state guaranty associations provide coverage is triggered when the company has been declared financially impaired or has been ruled to be insolvent by a court of law. However, there are some situations preceding such a judicial action when many associations may take measures to cover the impaired insurer's policyholder obligations, particularly for health benefits, death benefits, and immediate annuity payments. However, since the primary purpose of the guaranty associations is to protect policyholders, and not to bail out impaired or insolvent insurers, most associations are reluctant to provide coverage before an order of liquidation, unless it is clearly demonstrated that to do so in a particular case will be less costly over time.

Coverage Options: Guaranty associations may provide coverage directly, or through outside administration or other insurance companies. In many cases, the guaranty association will continue coverage for the full policy period. It may do this directly or it may transfer the policy to another insurer or administrator. In multi-state insolvencies, most guaranty associations work through NOLGHA to secure an assumption reinsurance agreement with another insurer or a claims servicing agreement with a third party administrator on a multi-state basis. If the impaired or insolvent insurer is licensed in more than one state, as most are, NOLHGA's affected member associations try to work closely through our Disposition Committee with domestic receivers to protect policyholders and insure early and equitable access of guaranty associations to the insolvent company's assets. On behalf of its participating member guaranty associations, NOLHGA's Disposition Committee expedites reinsurance assumptions, claims processing and audits.

Reinsurance

Reinsurance and insurer safety are closely related since reinsurance plays a vital role in helping all types of insurance companies meet their everyday commitments. Unfortunately, the reinsurance market has taken some heavy blows in recent years, including some direct links to primary insurer failures. Record losses and mismanagement in have caused many to leave or fold making reinsurance harder to come by and more expensive when you can.
The shakeout is a huge wake-up call for the industry, including agents, who need to be more alert to their own company’s reinsurance arrangements in the future. Some primary insurance companies who also sell reinsurance have suffered the hazards of double exposure by having to pay claims from both their primary and reinsurance divisions. It is also the contention of some industry groups that

abuse of the reinsurance system, including some questionable reinsurance schemes by depressed insurers and foreign reinsurers, has been a key factor in almost every insolvency.

Reinsurance Defined: Reinsurance is often described as the insurance of insurance companies because it provides reimbursement for the insurer's losses under policies covered by the reinsurance contract. Insurance placed with the reinsurer is called the ceded amount, and the company that receives the benefit of the insurance is called the ceding insurer. Insurance purchased by reinsurers to cover their own losses is called retrocession.

The process of reinsurance involves a transaction whereby the reinsurer, for a premium, agrees to indemnify the ceding insurer or reinsured against all or part of its losses under policies written. It is a transaction which does not involve the policy holder who looks only to his insurer for defense and indemnity against loss. Reinsurance is purchased by a primary or an excess ceding insurer for its own benefit so that it can spread its risks and limit its own liability from large or catastrophic losses. Reinsurance is often confused with excess or surplus line insurance. However, the two are totally unrelated.

Excess and surplus line insurers are primary companies providing direct coverage to insurance consumers. Their function is to supplement the standard admitted insurance markets. Excess and surplus line insurers are, in turn, large purchasers of reinsurance.

Sources & Reasons for Reinsurance: Reinsurance can be obtained through three distinct sources: professional reinsurers, reinsurance departments of primary insurance companies and unauthorized alien reinsurers. The insurance premium charged policy holders by insurers includes the cost of reinsuring the risk. In other words, there is no added charge to the policy holder.

The primary company calculates the premium on a gross basis and all reinsurance expenses are incorporated in the premium. The insurer has the responsibility to evaluate the risk in its totality and to price the risk according to the potential loss exposures. The distribution of the reinsurance premium between the insurer and the reinsurer is a separate transaction which does not involve the policy holder. There are many reasons primary insurers purchase reinsurance.

The two most important are to limit their liabilities and to increase their capacity. An insurance company may wish to cap its exposure to losses in one or a combination of three ways: a per risk limitation, a catastrophic loss limitation or an aggregate of loss limitation. Prudent insurance management and certain insurance regulations demand that a company place a limitation commensurate with that company's surplus or equity on any one potential loss exposure, even though the company may provide coverage under an insurance policy in amounts considerably in excess of this prudent "retention". This is where reinsurance comes in.

The individual company's retention may be anywhere from a few thousand dollars to several hundred thousand or even in the million dollar range. Whatever the loss exposure may be above the retention, up to the policy limits of the reinsurance contract, if any, becomes the responsibility of the reinsurer. Most companies also seek to protect themselves from a disastrous accumulation of losses arising from a single event.

No one single loss payment arising from the event might be beyond the company's individual risk retention level, but the accumulation of all the losses arising from the incident might be excessive for that company. Generally speaking, an insurer estimates the probable maximum loss to which it may

be exposed, based on its business concentration in any particular geographical area, compares that exposure to its surplus and purchases reinsurance to cover the potential losses which exceed a prudent level of catastrophic retention.

Another approach often used by companies to limit their potential liabilities attempts to cap the aggregate losses which may be sustained over a specific period either with respect to its total combined losses for the period or the combined losses for certain lines of insurance. The important reason an insurer may want to purchase aggregate loss reinsurance is to stabilize its operations from year to year. By providing a mechanism whereby companies may limit their loss exposures to levels commensurate with their surplus, reinsurance allows those companies to offer coverage limits considerably in excess of what they could provide otherwise.

This is a crucial function for small to medium size companies, allowing them to offer coverage limits which meet the needs of their policy holders. If only the larger insurers could do so, there would ensue considerably less competition and insurance capacity would be much more restricted than it is today.

Reinsurance further enhances an enlarged capacity by a variety of other approaches which are related to accounting procedures. When an insurance company issues a policy, the expenses associated with issuing the policy, such as taxes, agent commissions and administrative expenses, become a current charge on surplus, while the premium collected must be set aside as an unearned premium reserve.

The premium can only be considered as earned by the company and available to it over the life of the policy. This mismatch in accounting between premium and expenses makes good sense from a regulatory standpoint in that it allows for a more conservative accounting, commensurate with regulation for solvency. But it penalizes insurers to the extent that the more business they write, the more they must draw down on their surplus, thus reducing their capacity.

By reinsuring a part of the business written, an insurer is able to limit the impact of the mismatch since the reinsurer must reimburse its client company for its proportionate share of expenses. The reinsurer then is the one which must reduce its surplus by the expenses it absorbs from its reinsured. Similarly, when a claim is presented to an insurance company, a loss reserve must be established for the amount of anticipated claim payment. The reserve also comes from the company's surplus. However, to the extent a reinsurance recovery is anticipated on the claim and the reinsurer qualifies under state regulation, the insurer may limit its loss reserve to the extent of its own estimated "out of pocket" liability.

There are other approaches to reinsurance as a mechanism to enhance capacity. One such approach which was used perhaps to excess in the past is known as a "loss portfolio transfer". Under this transaction, the insurer "sells" a portion of its loss reserves to the reinsurer which promises to pay the claims represented by these reserves when they are finally adjusted. Assuming that the loss reserves being transferred to the reinsurer exceed the payment which the insurer makes to the reinsurer, the difference may be added to the insurer's surplus, thus, enhancing its capacity.

Reinsurers provide other services besides financial transactions aimed at limiting an insurer's exposure to losses, stabilizing an insurer's operation or enhancing its surplus to increase capacity. Many reinsurers are equipped to provide guidance to insurers in underwriting, claims reserving and

handling, investments and even general management. These services are particularly important to smaller companies or to those which may wish to enter new lines of insurance.

Limitations of Reinsurance: First and foremost, reinsurance does not change the inherent nature of risk being insured. Thus, it does not make a bad risk insurable. Neither is reinsurance, nor can it be made to be, a subsidy allowing underpricing of risks. Also, reinsurance does not make a risk exposure more predictable or desirable. While it may limit the exposure to a risk from the standpoint of the primary insurer, the total risk exposure is not altered through the presence of reinsurance.

Regulation of Reinsurance: Regulation cannot substitute for good management practices. The placement of reinsurance is a major responsibility of insurance management. It is a responsibility which cannot be substituted by regulation. There are many public and private resources and controls available to check the security and management of reinsurance companies.

All states today require reinsurance contracts to include certain clauses which are of overriding public policy. All contracts, for example, must contain an insolvency clause which requires the reinsurer to pay all reinsurance proceeds to the liquidator, in the case of insolvency of the insurer, without diminution resulting from the insolvency.
Probably the biggest issue with regard to reinsurance regulation is the control and policing of offshore or alien reinsurers. The U.S. is one of very few countries in which alien insurers may operate either through wholly owned subsidiaries or through branches or, in fact, both. A foreign domicile adds an additional layer of insulation between U.S. regulators and the reinsurer.

A simplistic approach would be to limit the U.S. reinsurance market to U.S. domestic or licensed companies. Traditionally, however, the international reinsurance markets have been the main source of retrocession insurance. The influence of the London markets, in particular Lloyd's of London, has been substantial. While it is true that reinsurers must file financial reports and are examined like primary insurers, there are some areas, where regulation of alien reinsurers falls short:

- Regulation of reinsurance cannot be so restrictive as to preclude adequate capacity. Regulators cannot be so rigid as to completely banish the supply of reinsurance.
- The channeling of reinsurance to more secure markets seems to be defeated by U.S. tax policy. The only tax on U.S. reinsurance premiums ceded to alien companies is the U.S. excise tax, a one percent gross premium tax. U.S. reinsurers, on the other hand, pay income tax equivalent to 7.5 percent of premium. The resulting difference has placed U.S. reinsurers at a major competitive disadvantage.
- The difficulties in regulating an international commodity such as insurance and reinsurance are, in part, due to the limited geographic reach of regulators, as noted in the report. However, the major difference is accounting conventions, country to country, are themselves major obstacles which would not disappear under a federal regulatory system. To establish minimum solvency standards for all companies doing business in the U.S. becomes a formidable task when these differences are taken into consideration.
- Currency fluctuation is another element which any international regulatory system must consider. Settlement payments could lose substantial value when siphoned through the "swings" of a wild currency exchange.

Underwriting

Underwriting is a critically important function and is performed each time an insurance application is taken. Its purpose is to determine if the applicant is acceptable to the insurer to determine whether or not the insurer will issue a policy. Underwriting is based on a variety of criteria, established by each insurer and regulated by state and federal law. Each underwriting decision involves balancing the insurer's desire to earn premium with the insurer's ability to cover claims and remain in compliance with regulatory financial requirements while making a profit.

What is Underwriting?

Underwriting is the function of evaluating the subject of insurance, whether a person, property, profession, business, or other entity, and determining whether to insure it. The underwriter must apply company standards to each applicant, and, based on these standards, ascertain whether the application represents an acceptable risk.

Underwriting is the foundation of the insurance transaction process. The term underwriter arose out of marine insurance. In the 17th Century, merchants who were willing to take on a portion of the risk for voyages would list the amount of the voyage they were willing to insure and sign their names underneath a contract that detailed the terms of the risk.

These merchants became known as underwriters because they wrote their names under the contract terms. Since that time, the insurance business has evolved and policies are no longer underwritten by individuals who insure risks, but the term underwriter continues to be applied to those who review and select risks to insure.

Factors in Underwriting

The factors used during the underwriting process varies somewhat, based upon the type of insurance being underwritten. If people are being insured, such as under life, health and disability insurance, key factors used in the underwriting process may include:

- Age
- Sex
- Health and health history
- Occupation and occupation history
- Financial condition
- Personal habits such as smoking or drinking alcohol
- Size of the policy
- Current insurance in force

If property is insured, as in homeowners, automobile, and commercial property insurance, underwriters may review factors such as:

- Type of the property
- Value of the property
- Condition of the property
- Construction materials used in the property

- Potential hazards surrounding or within the property
- Age of the property
- Use of the property
- Security measures and other loss control measures associated with the property
- Upkeep of the property
- Location of the property
- Current insurance in force on the property
- Prior losses associated with the property

If a business or business operations are being underwritten under insurance such as general liability and professional liability insurance, factors that underwriters will weigh include:

- Type of business
- Size of business
- Financial condition of the business
- Financial condition of owners
- Business cycles affecting the business
- Liability exposures
- Experience of key employees and owners
- Past losses experienced by the business

Functions of Underwriting

Underwriting involves examining application forms, supporting documents such as appraisals or bills that verify the value of property, or medical reports that verify the health condition of an individual, looking at insurance maps that provide information relevant to the statistical possibility of certain types of loss, reviewing statistical data applicable to the risk to be insured, reviewing company records regarding the application and evaluating site inspection reports.

Upon a thorough examination of all the data, underwriters then assign rates to the application, or decline to issue a policy if it does not meet underwriting standards. During the entire process, the underwriting department frequently communicates with agents, inspectors, adjusters and other field personnel.

Types of Underwriters

An insurance company may issue policies for many different types of insurance. However, most underwriters perform their responsibilities as specialists. An underwriter may underwrite just property policies, just casualty policies, just personal property policies, just professional liability policies, and so on.

Property and Casualty Underwriters

Within the property and casualty field, underwriters often specialize in a particular type of property or casualty coverage. Within this field there may be fire underwriters, homeowners underwriters, automobile insurance underwriters, inland marine underwriters, commercial property underwriters, personal property underwriters, commercial general liability underwriters, professional liability underwriters and Workers Compensation underwriters, for example.

These underwriters, whether they perform underwriting tasks for one line of insurance or for many lines, must understand the risks involved with each line of insurance for which they underwrite and the available and practical methods of dealing with these risks. They must also be able to gather and understand the various resources used to evaluate each application and determine whether the applicant meets company underwriting standards.

Such resources may include site inspection reports, business or personal financial statements and reports, and if a business is being insured, statistical reports generated by the industry in which the business falls, as well as statistical reports from the property and casualty insurance industry that are applicable to the risk.

Personal Line and Commercial Lines

A further distinction among property and casualty underwriters is whether they underwriter personal lines or commercial lines. Although both individuals and businesses need property and liability coverage, the insurance needs of an individual are very different from the needs of a business. In addition, there are many, many types of businesses and therefore many different sorts of risks associated with these varying business types. Therefore, within the commercial lines area, there may be many specialized underwriting functions.

If an underwriter works with commercial lines applicants, the underwriter is generally familiar with risk management principles and methods as they apply to the type of business being insured. Such underwriters also are knowledgeable regarding the type and scope of risks associated with various business occupancies. They understand that the risks related to running a supermarket are different from those that exist when operating a manufacturing plant.

Depending on the insurer, a commercial property and casualty underwriter may even specialize in underwriting specific types of businesses. For example, if an insurer markets to those needing boilers and machinery insurance and also to those with extensive data processing facilities, one set of underwriters may work with the boilers and machinery applicants and another set work with those with data processing protection needs.

If a property and casualty underwriter works with personal lines applicants, the underwriter will have a deep understanding of the specific risks facing individuals, such as homeowners or drivers. A homeowners insurance underwriter will understand differences in home construction materials, the safety impact of various security systems, and other factors that determine the rates and insurability of a homeowners applicant. A personal automobile insurance underwriter will be an expert in understanding the various safety features in all makes of cars, what types of drivers are statistically found to be safe drivers, and so on.

An underwriter working with highly valuable personal property owned by an individual will be familiar with appraisal reports and appropriate security measures that should be taken to protect the property.

Life and Health Underwriters

Another area of specialty for underwriters is life and health insurance. A life and health insurance underwriter is familiar with things such as the impact of medical history and other health issues on

insurability. The health or life underwriter is able to read and understand medical reports such as the attending physician statement and data gathered from the Medical Information Bureau.

Due to the extensive regulatory environment surrounding health insurance, health insurance underwriters are also very familiar with state and federal regulations regarding health coverage.

Liability Underwriters

Liability insurance underwriters must be familiar with the liability risks found inherently in commercial businesses, professionals or individuals. They must also be able to evaluate past losses, judgments and settlements in terms of the likelihood of reoccurrence in order to determine relative future risk. They must also be familiar with current trends in court judgments and with liability laws in order to property evaluate high-risk applicants.

Group Underwriters

Many types of insurance are written on a group basis, and health insurance is often written in this manner. Group insurance is handled somewhat differently than individual policies for underwriting purposes. Generally in life and health insurance group programs, a rate is established that applies to the entire group to be insured.

This rate is established by analyzing the characteristics of the group as a whole, as well as individuals within the group. This rate is generally reviewed and revised on an annual basis. Under some types of group underwriting, individual rates are assigned to individuals within the group, but a discounted rate is applied because the individual is part of the group, so the insurer's marketing costs are reduced on a per coverage basis.

A group offering automobile coverage to its members may have rates assigned in this way. Some forms of group insurance, especially when offered as part of an employer's benefit package, are subject to special federal and state regulations. Because group underwriting differs in operations and regulation from individual underwriting, an insurer may use specialized underwriters for group insurance.

Underwriting Decisions

When evaluating applicants, underwriters determine whether insurance on the applicant will be:

- Rejected
- Issued on a substandard basis
- Issued on a standard basis
- Issued on a preferred basis

Rejecting Applicants

Insurers reject applications for insurance when they find that the applicant represents a risk that falls outside of the underwriting standards established by the insurance company. These underwriting

standards take into consideration many items, such as regulations that require the insurer to establish adequate rates, laws that mandate that certain factors cannot be used to reject an application, insurance principles such as insurability and indemnity, the marketplace in which the insurer sells its products and the profit the insurer hopes to make on its business.

Issuing Policies on a Substandard Basis

The decision to issue a policy on a substandard basis occurs when a risk is not deemed to be outside underwriting standards, but is considered to be of high risk within those standards. The insurer generally has three basic options when it offers a substandard policy issue to an applicant. It may:

- Issue the policy with a higher premium than would be required for a standard policy
- Issue the policy with limited benefits
- Issue the policy with certain exclusions

Higher Premium: The insurer may charge a higher premium to applicants deemed to be of higher risk than those who would be considered a standard risk as long as those higher rates fall within certain parameters. First, if the insurance policy is one that requires that rates be filed with the state in which the policy is issued, the rate must be approved by the state. Secondly, the rate may not be discriminatory. The insurer must charge every insured with the same characteristics the same rate. Thirdly, in some states higher premium may not be charged based on certain items as defined in state statutes. The insurer must of course comply with such statutes in determining whether to charge higher premium rates.

Limit Policy Benefits: Insurers may also respond to substandard applicants by offering a policy with limited policy benefits. Again, whether the insurer may limit benefits is regulated by state law. For example, under long-term care policies, some states require that policies offer a minimum home health care benefit limit as a certain ratio of the nursing home benefit limit. Therefore, a long-term care insurer could not limit the home health benefit on a policy in a manner that would not comply with such a law.

Assuming state regulations are followed, an insurer could offer lower policy limits on certain coverages to a substandard applicant, or could offer lower policy limits for all coverages to such an applicant. Dealing with substandard applicants by limiting policy benefits is most common in commercial coverages.

Excluding Certain Provisions From Coverage: Another option an insurer may have is to offer an substandard applicant a policy that excludes coverage for certain property, insureds or operations that are deemed too high a risk for the insurer to cover. As with the other options discussed, such exclusions must be allowable under state regulations. This type of exclusion is most common in commercial property and liability coverages.

For example, an insurer may cover all the property owned by a business, except that within a building whose operations have been discontinued. Or, an insurer may offer to provide liability coverage for all business operations except for that portion that has potential pollution liability that is too high for the insurer to cover.

Issuing Policies on a Standard Basis

Underwriters base their determination that a policy should be issued on a standard basis on an analysis of the characteristics of the risk represented by the applicant. Applicants who are issued policies with standard rates fall within the normal boundaries of underwriting standards for that type of policy.

Issuing Policies on a Preferred Basis

If an application falls within the lowest risk boundaries of the underwriting standards, the policy is issued on a preferred basis. Preferred rates represent the lowest rates offered by an insurer for its coverage. Rates offered on a preferred basis must adhere to the insurance regulations applicable to them, just as rates offered on a substandard and standard basis must. Insurance regulators do not want insurers to offer rates that are so low that the insurer cannot meet its contractual obligations to pay covered claims.

Monitoring Underwriting Decisions

Once a policy is issued, underwriters continue to monitor the policy from an underwriting perspective. Such monitoring is done at policy renewal, commonly every six or twelve months, and as claims occur. Depending upon the type of policy and its provisions regarding rate increases, rates may be increased at renewal, or the insurer may make the decision not to renew the policy.

Changes in rates or the decision to non-renew are only made if allowed by policy provisions and applicable regulation. Decisions to modify rates may be based on the actual claims experience over the last policy period for a specific insured, as may occur with Workers Compensation insurance and various commercial property policies, or may be based on a rate change for an entire class of policyholders or category of insurance. State regulations often limit factors that may be used to increase rates.

For example, a state may not allow an increase in automobile rates until three claims have been paid under the policy. The decision for non-renewal, if allowed by regulation and policy terms, is typically done only if the insured has excessive claims or the insurer has decided to discontinue offering the type of insurance the policy represents. The agent also has a role in the monitoring of underwriting decisions. The agent should meet with each client on an annual basis to review coverages and ensure all information on file with the insurer is accurate and up-to-date.

This review of coverage also serves the purpose of making sure the client’s insurance needs are properly met. Contact between the agent and client outside of the annual review may also result in the receipt by the agent of updated policy information.

Updating policy information is an important part of the ongoing underwriting process. It is your duty as an agent of the insurer to promptly and accurately submit to the insurer’s home office. Any changes in your client's information may affect coverage.

The Underwriting Process

Underwriting is the process of determining whether an insured is an acceptable risk, and if so, at what rate the insured will be accepted. Insurers cannot accept every applicant. An insurer has a responsibility to its current policyholders to make sure that it will be able to meet all the contractual obligations of its existing policies. If the insurance company issues policies on applicants that represent risks that are uninsurable or risks that require premiums higher than the insurer may charge can cover, the insurer's ability to meet its contractual obligations is jeopardized.

On the other hand, a for-profit insurer wants to make money and to increase its number of policyholders. No insurer wants to reject applicants unnecessarily. All these factors must be taken into consideration in the underwriting process. An insurer is also regulated by the states in which it does business. The states expect the insurer to establish reasonable, non-discriminatory standards for accepting insureds. Rates for many types of insurance must be approved by the states in which the insurer does business. Regulation is another important factor in the underwriting process.

Establishing An Application File

When an application is received in underwriting, the insurer's underwriting process begins. The application is reviewed to make sure it is complete, and that the application, on its face, meets underwriting standards. At this point it is also determined whether or not additional documentation will be required. If additional documentation is required, the underwriting department will request the documentation, reports or inspections, or will notify the agent or agency that these items are needed.

Because the length of the underwriting process and policy issue is often governed by state regulations and company standards, the request for information, reports and inspections generally include a specified period of time in which the request must be fulfilled. If the information is not received within the specified time, the application file is generally closed, and any premium received is returned. Often the first review of the application includes the determination of whether the risk demonstrates appropriate insurable interest. Insurable interest must exist in order for the application to continue through the underwriting process.

Insurable Interest

Often, the first characteristic of an acceptable insurance risk reviewed is whether it includes insurable interest. Requiring insurable interest helps to reduce the likelihood that the person or persons benefiting from the insurance will try, in some way, to cause or allow a loss. The definition of insurable interest varies depending upon the type of coverage being issued.

Under property insurance, the person who benefits from a property insurance policy must generally meet three requirements. He or she must:

1. Be in a position to suffer a loss related to the insured or the insured property
2. Must not be in a position to profit or gain from a loss pertaining to the insured or the insured property
3. Must have a financial interest in protecting the insured from a loss

Under life insurance, for insurable interest to exist, the death of the insured must have a clear and definite financial impact on the policy owner. Insurable interest in life insurance is considered to exist if the policy owner and insured are the same person. It is also considered to exist if the spouse of the insured is the policy owner, if a parent is the policy owner and the parent's child is the insured, if a grandparent is the insured and policy owner is a grandchild, if a business is the policy owner and the insured is a key employee or an officer or director of the business, and if business partners own policies on the lives of one another.

If a creditor is the policy owner and the debtor is the insured, there is insurable interest up to the extent of the debt only. Other relationships may include an insurable interest, but an underwriter is likely to ask for proof of such interest before accepting an application with an unusual insurable interest relationship.

Elements of a Valid Contract

Another important factor an underwriter will look for in any insurance application is verifying that it complies with rules surrounding legal and valid contracts. Insurance contracts, like all contracts, must include four elements in order to be legal and valid:

1. Consideration
2. Agreement or assent of the parties
3. Competent Parties
4. Legal purpose or legal subject matter

Consideration

Consideration is something of value that induces the parties involved into making a contractual agreement. Consideration may be monetary, or can be in the form of a promise or an act. Under an insurance contract, premium is the consideration.

Assent of Both Parties

Under contract law, parties involved in a contract must agree to contract terms as they exist. This legal concept is known as mutual assent. In order for a contract to be valid, agreement cannot be made under any kind of duress, by mistake, or by any fraudulent means.

Competent Parties

A competent party is one having the legal capacity to enter into a contract. A minor does not have legal capacity to enter into a contract, nor does a person who has been declared legally insane, or those who are under the influence of intoxicants.

Legal Purpose

Every contract must be entered into with a legal purpose. If a contract has an illegal purpose, it is void. Examples of illegal purposes that might be found in life insurance are policies opened with the intent to commit murder or to falsify the death certificate of an insured in order to collect the death benefit. In property insurance, a contract with an illegal purpose may be one entered into in conjunction with a contract with an arsonist to burn the property insured.

Property-Casualty Contracts

In property-casualty insurance, most states prohibit policy forms that include provisions, exceptions or conditions that are misleading ambiguous, deceptive, overstate the coverage or misrepresent the coverage in the policy. States may also require that the policy contract include notices regarding the policy's cancellation or non-renewal. If the policy is a personal lines policy such as a homeowner's or personal automobile policy, it will generally have cancellation and renewal provisions that are more lenient for the consumer than a policy written for a business.

For example, the insurer may have to return premium to a non-business insured more rapidly than the insurer must return premium to the named insured on a business policy. States may also require that a declaration or information page be included in the policy form that identifies the individual insured, the property to which the insurance applies, any of minimum liability, and the effective date and time of policy inception.

The policy form may also be required to include a clear insuring agreement, conditions under which the coverage applies, exclusions from policy coverage, definitions of important words in the policy, a statement that bankruptcy does not relieve the insurer of its obligations, an arbitration clause, an appraisal clause and a statement that the policy form and endorsements constitute the entire contract.

Exempt Commercial Policyholders: Under some state insurance regulations, certain commercial policyholders are exempt from rate and form requirements that would normally be applicable. An exempt commercial policyholder under these regulations is one who is a sophisticated business purchaser. Such a purchaser is likely to study and understand insurance coverages exclusions and the risks to which their business is subject.

An exempt commercial policyholder may be one requiring customized insurance coverage rather than coverage through a filed form from the insurer. To qualify as an exempt commercial policyholder, a state may require that the policyholder be of a certain size, for example, requiring that the business have a net worth of over a certain amount or requiring that net revenues or sales be over a certain amount. Other requirements may include that the policyholder employ a risk manager or pay annual insurance premiums of a certain minimum amount, such as at least $500,000.

Insurable Risk

Another key aspect of each application reviewed by an underwriter is the determination if the risk the application represents is an insurable risk. Not all risks are insurable. As each risk is evaluated, it is important to note whether or not it can be insured. If not, insurance may not be purchased on the risk.

In order to be insurable, a loss must:

- Arise from a pure risk
- Be definable
- Be calculable
- Not occur to many people simultaneously
- Not be intentional

Pure Risk

A pure risk is one which cannot result in the possibility of gain. In order to be insurable, a risk must have the potential of only two possible results: loss or no loss. If a risk includes the possibility of gain, it is called a speculative risk. Launching a marketing campaign is an example of a speculative risk.

It may result in a loss in sales if people are turned off by the advertising, it may result in neither an increase nor a decrease in business if the advertising makes no impact, or it may result in increased sales. Insurance policies do not provide insurance for speculative risks. Insurers protect against pure risks such as fire.

If no fire occurs, no loss occurs. If fire occurs, loss occurs. Liability claims or suits are pure risks. If a liability claim does not occur, no loss occurs. If a liability claim occurs, loss occurs, ranging from defense expenses to the payment of a damage award.

Definable Loss

Insurance covers losses that can be defined in terms of cause, time, place and amount. Cause must be definable in order to make sure that the coverage applies to losses arising from the cause.

Time must be definable in order to make sure the loss occurred during the policy period or whatever terms the policy provides regarding the period of time in which claims may be made.
Place must be definable to ensure that the loss occurred within the coverage territory stated in the policy. Amount must be definable so that the insurer pays the benefit due under the benefit limits of the policy.

Calculable Loss

Insurers must be able to calculate both actual and expected losses. Expected losses are the basis of premiums charged. Actual losses may result in an adjustment of premium in the preceding period and for ongoing coverage. Actual losses also are the basis for paying benefits from the policy.

Not Occur to Many People Simultaneously

In order to provide insurance, premiums must be collected from a large number of people exposed to the same type or types of loss. Even though the insureds are exposed to the same type of loss, the exposure for each insured must be independent. If all the insureds were exposed to loss by the same fire; for example if they all operated businesses in connecting wood buildings on the same street the insurer would not have sufficient premium to pay for their losses should a fire break out.

In order for the insurer to pay all claims, losses must occur to a certain expected percentage of the insureds at a certain expected frequency. If a large number of the insureds are all affected by the same loss exposure, the insurer will either have to charge premiums of an amount that would make the insurance unaffordable or no more affordable than if the business were self-insured, or the insurer will not have sufficient premium collected to pay for losses suffered.

Unintentional Losses

Intentional losses are never insurable. First of all, intentional losses do not fit the models of probability used to determine premium amounts. Premium amounts are based on the frequency and severity of unintentional losses. Secondly, intentional losses may be criminal or fraudulent. Contracts must have a legal purpose. Insurance may not pay for losses which arise from illegal activity.

Applicable Factors for Underwriting

Once it is established that insurable interest exists, the application would result in a valid contract and the risk the application represents is insurable, the underwriters evaluate the basic characteristics of the risk. Each line of insurance is underwritten using pieces of information unique to that type of coverage. Most of the information is found on the application for the insurance, and additional data is provided through supporting reports, documents and inspections.

Under life and health insurance, information related to the medical history of the insured is weighed, as are the occupation and hobbies of the insured. Under property insurance, the property may be inspected or documents may have to be submitted that verify the value and condition of the property described in the application.

In liability insurance covering a business, site inspections and contracts used by the business, as well as other documents related to the business and its operations, may be required. Liability coverage for a home or auto insurance policy may also require an inspection of the property. Many forms of insurance require financial information to be submitted for the underwriting process.

When individuals are covered, personal financial records may be needed. When a business is covered, the business' financial statements are generally submitted. If a professional is covered, both personal and business financials may be requested.

Determining Rates

Once all the information pertaining to the application and supporting documentation is evaluated, the underwriters determine whether a policy should be issued, and if so, what premium should be charged. As was discussed in the last chapter, policies may generally be issued with standard rates, substandard rates or preferred rates.

Rate Determination Methods

In many cases, state insurance law directly impacts rate determination. Some states promulgate rates for certain lines of insurance, and the insurer must use these rates for the insurance they issue in such lines. States may allow insurers to file rates for various lines of insurance.

A range or band of rates is filed with the insurance department and the insurance company may use these rates and issue insurance once the insurance department of the state has approved the rate band. Another method states may allow is to require the insurer to file rates and then use these rates unless the insurance department in the state notifies the insurer that the rates are not allowable.

Insurers are required to give due consideration to past and prospective loss experience, to the type and scope of hazards, to a reasonable profit margin, to dividends and return of premium, to past and prospective expenses and to any special assessments when setting rates.

Judgment Rating

Within the parameters of state law, underwriters may use one of three methods to assign rates. One method is known as the judgment method. Judgment rating refers to the underwriter using his or her own knowledge and experience to determine the rate that should be assigned to the applicant. No specified rates are applied.

This sort of rating is normally done for special lines of insurance or for lines of insurance that do not require rates to be approved by the state.

Manual Rating

A second method used to determine rates is more and more commonly used, especially in heavily regulated lines of insurance. This method is known as manual rating. Under manual rating, pre-determined rates found in manuals are used to set rates for each policy. Manual rates may be promulgated by the state insurance department, or may be developed within the insurance company or by a rating bureau.

Merit Rating

The third method of setting rates is known as merit rating. Under merit rating, manual rates are used and then modified based on specific characteristics of the risks. Modifications to rates may be based on the experience of the insured over a specified period prior to and sometimes including the policy period or on the experience of the specific insured during the policy period, or on a schedule that quantifies applicable risk characteristics.

Experience Merit Rating

When the experience of the insured over a specified period is used, the applicant is generally asked about relevant behavior or occurrences applicable to the insurance coverage. This type of merit rating is known as experience rating. For example, a driver may be asked about traffic violations that occurred during the last three years. Rates are based in part on the number of such violations over this period.

Retrospective Merit Rating

Another type of merit rating involves the underwriter reviewing the loss experience during the policy period and setting a rate based on that loss experience. This type of merit rating is known as retrospective rating. This sort of rate setting is often done in commercial lines of insurance and in Workers Compensation insurance.

Scheduled Merit Rating

A third type of merit rating, scheduled rating, is a sophisticated form of manual rating. Manual rates are used as the base rate, and rates are added or subtracted from this base rate based on amounts

determined for various risk characteristics. For example, the use of certain fireproof construction materials may result in a reduction of the standard rate under this type of rating system.

Regardless of the type of method used to assign rates, rates are determined by evaluating the relative frequency and severity of a risk. Severity refers to the amount of financial loss that is likely should a risk occur. Frequency refers to the number of times a loss is likely to occur. A loss likely to be infrequent and small is less expensive to the insurer than one that may be infrequent and large, or one that is both frequent and large.

Competitive Markets and Rate Setting

Another component of rate setting regulations of many states is the determination of whether a competitive market exists. Some states require the insurance commissioner to evaluate the amount of competition offering various lines of insurance. The methods the insurance commissioner may take in determining the presence of a competitive market may include conducting hearings and tests pertaining to market structure, market performance and market conduct.

In a competitive market, consumers are able to easily compare insurance products and obtain insurance from competing insurers. Non-competitive markets may exist for high-risk insureds, such as those living in the path of severe windstorms, or insureds who have, or are statistically likely to have, a high number of claims. If a competitive market does not exist, the commissioner may be required under state insurance law to take steps to provide consumers within the non-competitive market with the ability to purchase insurance.

Actions a commissioner may take include requiring insurers doing business in the state to provide insurance products for people unable to purchase them in the normal marketplace. The commissioner may set rates for these products or mandate that rates be kept within a certain level. Another action that may be taken in states where it is determined noncompetitive market exists, is that the state will form an insurance pool to cover the needs within this noncompetitive market.

In insurance rate regulations, the definition of an excess rate may include the presence of or lack of a competitive market. For example, a regulation may state that insurance rates in a competitive market are automatically presumed not to be excessive. Also in some states, if a competitive market exists, insurers may not have to file rates to keep doing business in the state.

Such insurers may still have to file rates for information purposes and for use by the commissioner in determining that a competitive market still exists, but insurers within a competitive market may be exempt from the rate renewal filing requirements of insurers within a noncompetitive market.

Terms at Policy Issue

Besides setting specified rates, the applicant may be required to meet underwriting requirements in order for insurance to be issued or remain in force. For example, a business may be required to install a sprinkler system, a homeowner may be required to add railing to a deck, and an individual with a valuable coin collection may be required to place it in a safety deposit box in order for the insurance to apply.

Underwriting Resources

Many resources are used during the underwriting process. The most important of these resources is the application.

Insurance Applications

The insurance application is a critical underwriting resource. From it, the underwriter finds most of the basic information needed to determine whether to issue a policy, and if so, at what premium and terms.

Life Insurance Applications

Each life application generally requires the following type of information:

- Applicant and insured name, address and other general information
- Medical information
- Agent's statement
- Selection of riders or optional features
- Signatures

General Information: The general information section of life insurance applications generally asks for the name, address, birth date, social security number and gender of the insured and owner. The relationship of the owner to the insured is also needed.

The name or names of beneficiaries is also requested, along with the percentage for each beneficiary or other beneficiary designation, and the relationship of each beneficiary to the owner. Some applications also require the beneficiary's social security number. This is to aid the insurer in identifying the proper beneficiary, if necessary.

Medical Information: Medical questions include asking whether tobacco or nicotine products have been used, and if the insured had been diagnosed, treated or hospitalized for:

- Cancer
- Heart attack
- Stroke
- Diabetes
- Kidney disorders
- Alzheimer's disease
- Liver disorder
- Organ transplant
- Alcohol or drug use treatments
- AIDS or HIV
- Irregular heart beat
- High blood pressure
- Fainting spells
- Emphysema or other chronic lung or respiratory disorder

- Inability to work for more than a week in the past six months or year
- Other similar questions

If there is a "yes" response to the medical questions asked, the application will generally ask for more details. Once the application reaches the home office, medical reports or an attending physician statement may also be requested. Or, the insurer may have issued underwriting guidelines to the agent, who requests such reports through his or her agency office.

Replacement: Each application also asks whether this proposed insurance will replace or change any existing or pending insurance. If the applicant answers "yes" to this question, the agent may be required by state regulations to complete state replacement forms with the applicant.

State replacement forms generally include comparative information for the applicant to read regarding the proposed insurance and the policy to be replaced. They may also include disclosure statements for the applicant to sign indicating that the applicant understands that there may be surrender charges involved in canceling the existing policy, that the new policy generally includes commission loads and that a new surrender charge period may apply to the new policy. In insurance company required "1035 Exchange" or "Absolute Assignment" form must also be completed in a replacement situation.

Duties of Agents Regarding Replacement: The National Association of Insurance Commissioners, or NAIC, drafts Model Regulations regarding many insurance practices. The various states adopt these model regulations and may also amend them as their legislators find appropriate. Included in the NAIC's Model Regulation for Life Insurance and Annuities Replacement, are "Duties of Producers."

Under this Model Regulation, an agent who initiates an application is to submit to the insurer a statement signed by both the applicant and the agent stating whether the applicant has existing policies or contracts. This statement may be part of the application form or a separate document.

If the signed statement indicates that replacement is not involved, the agent has no further duties. However, if the applicant answered "yes" to the question regarding replacement under the Model Regulation, the agent must give and read to the applicant a notice regarding replacement in a form recommended by the NAIC, or a similar one approved by the insurance commissioner of the state in which the agent is doing business. The NAIC recommended disclosure form includes the following items:

- A place for the agent and applicant to sign for the receipt of the form
- Definition of a replacement in consumer-friendly terms
- A statement to the effect that the new policy may include acquisition costs and that surrender charges may apply to the existing policy
- A place for the applicant to indicate the policy number and insurance company of the policy or policies which are to be replaced
- A statement recommending that the applicant contact their existing insurance company or his or her agent for information about the old policy
- A space where the applicant can indicate why the old contract is being replaced
- Suggested questions for the applicant to discuss with both the new and old agent regarding: premium amounts and the length of time premiums must be paid; the surrender charges, expense and sales charges applicable to both policies; whether suicide limitations apply to the new policy; whether a medical exam must be undergone

for the new policy and the current insurability of the applicant; how the interest rate guarantees and current crediting rate compare; and the tax ramifications of the transaction.

Under the Model Regulations, besides the notice, the agent is required to leave a copy of all sales material at the time an application for a new policy is completed, or if electronic material is used, no later than the time of policy issue.

Violations and Penalties: Also included in this Model Regulation are the ramifications of violating the Regulation. Examples of violations to the Regulation include:

- Deceptive or misleading information in the sales material
- A failure to ask the applicant the questions regarding replacement
- Intentionally recording an incorrect answer
- Advising an applicant to give a negative answer regarding questions about replacement in order to keep from having to notify an existing insurance company
- Advising an applicant to contact the existing insurer directly so that the replacing agent or company is obscured

If an agent has a regular pattern of having customers say they are not replacing insurance contracts on an application, and then afterward replaces the insurance contracts, the Model Regulation states that such action is considered “prima facie” evidence of the agent’s intent to violate the regulation.

Under the Model Regulation, violators of the Regulation are subject to penalties that may include the revocation or suspension of an agent’s or company’s license, monetary fines and the forfeiture of any commissions or compensation paid to a producer related to the transaction in which the violations occurred. In addition, the insurance company may be required to take restitution, restore policy or contract values and pay interest at a specified rate on the amount.

Agent Statement: The agent has a responsibility to the insurer to report to the insurer on the application to provide information the insurer requests, such as how long the agent has known the applicant, whether the agent has knowledge that the proposed insurance is being purchased to replace existing insurance and to supply basic information the agent has knowledge of regarding the applicant’s health, financial situation and general character.

Selection of Features and Options: Depending on the type of policy applied for, the applicant will make several choices regarding the insurance coverage. All policies, other than single premium policies, generally provide a choice of payment frequency, including monthly, quarterly, semi-annual or annual payments. Many insurers offer the option of pre-authorized checks so the premium amount may be withdrawn directly from the applicant’s bank account.

If the policy is to include any riders, the applicant must indicate his or her selection. If the policy has an option of death benefits, the applicant must also select the death benefit option desired. If the policy includes variable sub-accounts, the applicant must select the initial sub accounts into which cash values will be placed and the percentage to be placed into each one. Variable policies may also offer the ability to make telephone transfers among sub accounts and other similar features the applicant must authorize.

Occupation/Hobbies: If the applicant is involved in certain occupations or hobbies, or is surrounded by certain sets of circumstances, a completion of a questionnaire designed for that occupation, hobby or circumstance may be required by the insurance company. Examples of items that may require the completion of a questionnaire include involvement in aviation, skydiving, military service, having foreign residency, and being in certain finance related occupations.

Disclosures: Applications or accompanying documents also include disclosures regarding the Medical Information Bureau and the Fair Credit Reporting Act. The applicant must sign indicating receipt of these notices. The applicant must also give the insurer written permission to obtain consumer and investigative consumer reports. Another important responsibility of insurance agents is to supply buyer's guides in accordance with state regulations. The agent must also be prepared to answer the consumer questions included in buyer's guides.

Dividend Options: If a life insurance policy is a participating policy, the application will include a section regarding the owner's dividend options. A participating life insurance policy participates in the earned surplus of the insurance company. Dividends may be paid to policy owners from such policies.

Dividends may result from the insurer paying out claims in amounts that are lower than expected. This condition is known as positive experience. Dividends may also be paid because investment earnings are higher than expected or expenses are lower than expected.

However, dividends do not have to be paid under such circumstances. They are paid at the discretion of the insurer. Options for dividend payments generally include:

- Payment in cash
- Reduction of premium due
- Leaving on deposit
- Purchase of paid-up additions
- Purchase of term insurance

Receipt: Once the applicant has completed and signed the application, in some cases, the applicant gives the first premium check, made out to the insurance company, to the agent. The agent then gives a receipt to the applicant. In other cases, the first premium is not collected until policy delivery.

Submission to Underwriting: The agent is then responsible to submit the application and any premium received to the insurance company.

Health Insurance Applications

Health insurance is often issued under a group policy through an employer. An application for coverage under a group policy is often simpler than an application for individual coverage, but both types of applications ask similar information. A group application from an employer will normally include the following elements:

- Employer name
- Employer plan group number
- Employee name
- Employee address and phone number

- Date of hire
- Employee position or title
- Sex of the employee
- Birth date of the employee
- Marital Status
- Whether the employee uses tobacco
- Whether the application for coverage is based on COBRA (this is a federal law requiring the ability of terminated employees to continue health coverage under certain circumstances)
- Deductible amount, if any
- Coverage options, such as whether dental coverage or prescription drug coverage is to be included
- Dependent coverage information for spouse and children
- Prior coverage information (this information is necessary to comply with federal health coverage rules for group policies)
- Medical information:
    - Height and weight of adults covered
    - Whether any insured has had medical treatment for his or her back, colon, liver, kidney, diabetes, intestinal tract, muscular system, respiratory system, heart or circulatory system, or for any cancer,
    - convulsions, a stroke or mental or emotional issues
    - Whether treatment had been received for alcohol or drug use
    - Whether the applicant had been diagnosed or treated for HIV, AIDs or ARC
    - Whether the applicant or any insured is pregnant
    - Whether there has been treatment or diagnosis related to any insured's ear, eye, joint, ulcer, rectal, hernia, allergy, asthma, arthritis, breast, thyroid, prostate, headache, gallbladder, urinary
    - tract, digestive system, reproductive organs, or high blood pressure
    - Whether any insured has any other medical condition not included elsewhere in the application
    - Request for additional explanation on any medical condition indicated on the application

The information on the health insurance application is necessary for the underwriters to properly underwrite the coverage. In the case of group insurance, the items related to the employer and the employer plan group number is used for the basic purpose of placing the employee within the proper group plan. Date of hire and position in the firm is used to make sure the employee is identified correctly, and because under some benefits programs, the amount the employer pays for health benefits varies based on the length of time an employee is on the job and the position of the employee.

Applications include a question regarding whether the coverage is based on COBRA because COBRA coverage is governed by federal laws. The insurer must make sure that all these laws are complied with if the health coverage does fall under COBRA. Prior coverage information is also important because both federal and state law requires that certain waiting periods and exclusions may be reduced through the application of prior coverage periods.

Optional coverages such as dental and prescription drug impact rates and terms of the coverage applicable to the insured. The age, sex, marital status and use of tobacco all relate to characteristics

of the risk that are used to determine rates for the health coverage. The more detailed health questions also are used to determine the type of health risk the applicant represents. Depending upon the answers given, the underwriter may need additional information, such as attending physician statements and other medical reports.

Disability Income Applications

Disability income insurance is a form of health insurance, but includes important factors not relevant in other forms of health insurance such as medical expense coverage. Disability income insurance provides payment if the insured becomes disabled as defined under the policy. Underwriting in disability income insurance does not just look at the current health and health history of an insured, but also attempts to determine less easily documented risk characteristics related to the motivation of an insured to return to work should a disability occur.

Disability income insurance applications generally include the following items:

- Age of the insured
- Sex of the insured
- Occupation of the insured, including details regarding the insured's position Medical history
- An explanation of medical conditions, including their frequency, severity and likelihood of recurrence
- Height and weight of the insured
- Blood pressure and other health indicators
- Financial information such as the applicant's income, unearned income and net worth
- Mental health history
- Treatment for drug or alcohol use
- Prior coverage history
- Claims history

Disability income insurance applications include information regarding the medical history and current health conditions of an applicant that is similar to that found on other health insurance applications. However, disability underwriters are more concerned about whether or not a medical condition will lead to disability than are underwriters of other forms of health insurance.

Disability income insurance applications also include information regarding the financial status of an applicant that is not found in other forms of health insurance.

This is because disability underwriters attempt to issue policies with benefit levels that do not encourage an insured to submit claims in order to better their financial position. Even the most generous disability income benefits are generally designed to meet basic income needs of the insured, not to give an insured a higher income than he or she would have had if the insured had been able to keep working.

Disability income policies also include information regarding the position of the insured within a business. Individual disability income policies are often marketed to owners of businesses, professionals or key executives.

One reason that disability insurers look for such individuals to purchase their policies is that such individuals are generally highly motivated to return to work, meaning that disability income payments may not continue as long as they would for someone with less motivation to return to work.

Long-Term Care Insurance

The common underwriting factors included on a long-term care insurance application are the following:

- Age
- Sex
- Medical History, including
    - Heart attack
    - Diabetes
    - Cancer
    - High Blood Pressure
    - Arthritis
    - Renal disease (kidney failure)
    - Respiratory distress that requires oxygen use
    - Schizophrenia
    - Dementia
    - Spinal cord disorders
    - Multiple strokes
    - Systemic lupus
    - Most recipients of transplants
    - Tuberculosis
    - Multiple episodes of fainting
    - Severe growths or tumors
- Current medical condition
- Whether the insured has undergone drug or alcohol abuse treatment
- Family medical history
- Occupation

Long-term care insurance underwriting, as a form of health insurance, involves reviewing medical and health factors. Statistics related directly to long-term care are used to evaluate each risk and establish rates. For example, the sex of the applicant is important because women, due to having a longer life expectancy than men, are more likely to need some type of long-term care services.

Each type of medical condition an applicant may have is thoroughly scrutinized in long-term care insurance underwriting. The frequency and severity of the individual's condition is evaluated to determine insurability and applicable rates. For example, if an applicant has diabetes, yet does not have to take insulin or is on low doses of insulin, the underwriter may still deem the applicant as insurable. However, more advanced cases of diabetes may render an applicant uninsurable.

Certain types of medical conditions or behaviors may cause a long-term care application to be rejected. Drug abuse, alcoholism, kidney failure, schizophrenia, dementia, spinal cord disorders, multiple stokes, systemic lupus, tuberculosis and severe growths or tumors may cause an applicant to be deemed uninsurable.

Homeowners Application

Homeowners applications generally include the following information:

- Applicant's name
- Applicant's address
- Type of coverage requested (actual cash value, replacement cost, or other)
- Location of home
- Details regarding the home, including
    - Year built
    - Square footage of dwelling
    - Square footage of adjacent structures
    - Number of families
    - Number of stories
    - Type of roof
    - Value of personal property
    - Whether the home includes a wood stove
    - Construction type (masonry, wood, other)
- Location of fire station, hydrant and fire district
- Mortgagee/Loss Payee information
- Additional coverage information (e.g. earthquake coverage)
- Discounts for which the homeowner qualifies
- Prior/Current Insurance Carrier and policy information
- Whether the homeowner has filed or is filing for bankruptcy
- Whether the homeowner is delinquent on house payments or taxes
- Whether anyone with a financial interest in the property has been convicted of fraud, arson or any other crime on property over the past five (or other specified time) years
- Whether there is a pool, and if so, if it is fenced
- Whether there is a pond, lake or dock on the premises
- Whether there is a hot tub on the premises
- Whether there is a trampoline on the premises
- Whether there are animals on the premises, and if so, what breed and if there has been a history of biting
- Whether there is a business on the premises, and if so, what type
- Description of other structures on the premises
- Whether the electric service is on circuit breakers
- Whether the home is the primary residence of the insured
- Whether there is existing structural damage
- Whether there are smoke detectors on the premises
- Whether there is brush or landslide exposure
- Type of wiring and plumbing and roofing
- Whether the property has been inspected by the agent
- Space for additional documentation, including photos of the property

The information on homeowners applications is used to determine insurability and rates under both the property coverage and liability coverage provided under homeowners policies. Items such as the

location of the home, the construction materials used, and the age of the home most directly affects the property coverage. Insurance maps used by the underwriters help to determine the risk of fire and theft the homeowner may experience due to its location and are used for property insurance underwriting.

The physical condition of the home, whether a pool, hot tub or trampoline are on the premises are more important factors for the liability insurance underwriting aspects of the policy.

Personal Automobile Application

Applications for personal automobile insurance generally include the following:

- Name and address of the named insured
- The year, make and model of autos to be covered
- Current automobile policy information
- Whether the autos are used for business or pleasure
- Whether the autos are used to drive to and from work and if so, how many miles to work
- The annual mileage of the autos to be covered
- Information on the drivers of the autos, including:
    - Driver's name
    - Driver's marital status
    - Length of time as drivers
    - Whether the drivers had any at fault claims, traffic violations or a loss of license in the last three years
- Amount of liability, collision and comprehensive coverage desired

Factors used in automobile insurance underwriting include the age of the driver, the sex and marital status of the driver and the driver's record.

Statistically, single persons tend to have more accidents than married persons and younger people, particularly younger males, tend to have more accidents than do older adults.

The amount of miles the auto is driven also has been statistically determined to impact the likelihood of an accident involving the automobile. The type of automobile or automobiles covered impacts the amount of damage the automobile is likely to cause to another auto, and the safety of the driver and passenger.

Likelihood of theft is also based on the make and model of the automobile insured and where it is garaged.

Commercial Automobile Application

Commercial automobile applications are completed by a named insured on behalf of the business owning the covered automobiles. These applications generally include the following factors:

- Name and address of named insured
- Garaging address of vehicles
- Type of business (individual, partnership, corporation, or other)

- Length of time business has been in operation
- Description of business operations
- Business' gross receipts for the current and past year
- Type of commodity transported
- Whether there is any exposure to flammables, explosives, chemicals or hazardous materials
- Area of business operations
- States in which vehicles are operated
- Large cities in which vehicles are operated
- Whether or not the business hauls cargo for others, and if so, details of such
- Whether vehicles are parked at a jobsite most of the day
- Whether vehicles are loaned, rented or leased to others, if so, under what terms
- Whether vehicles are loaned, rented or leased from others, if so, under what terms
- Whether vehicle owner/operators are used, and if so, under what terms
- Whether sub-contractors are used, and if so, under what terms
- Whether any employees use their own vehicles for the business
- Whether any family members use company-owned vehicles
- Whether passengers are allowed to ride in vehicles
- Whether all drivers are covered by Workers Compensation coverage
- Driver information, including:
    - Whether drivers are employees
    - Whether drivers are paid by the hour, by the load, or some other way
    - Whether there is a formal driver safety program
    - The maintenance program in place
    - Whether drivers are screened upon hire
    - Specific driver information, including name, driver's license number and other specifics
- Vehicle information, including:
    - Type and number of vehicles owned
    - Type and number of vehicles leased
    - Specific vehicle information, including model, type of vehicle, seating capacity, driving radius and garaging location
- Information regarding federal and state vehicle permits
- Prior loss information
- Policy limit and coverage information

Many of the items included in a commercial automobile policy are the same as those found in personal auto policies. The make and model of vehicle, where it is garaged and the drivers' records are all important underwriting factors. In addition, the territory in which the auto is used, and the cities in which it is driven are taken into consideration because more accidents occur in some places than in others. Some of the questions on the application are used to determine if endorsements should be utilized in the coverage.

For example the liability coverage of commercial auto policies exclude autos owned by employees. If employee-owned autos are used in the business, the business owner may want to add liability coverage for such autos through an endorsement. State and federal permit information is requested

to make sure the business is in compliance with state and federal laws regulating the use of the vehicles, and to provide underwriters with information regarding the use of the vehicles.

Commercial Property Application

Applications for commercial property coverage generally include:

- The name of the named insured
- The address of the named insured and the business owning the property to be covered
- Location of all property to be covered
- Description of property to be covered
- Value of property covered
- Security devices and other loss control measures related to the property
- Current amount of insurance in force on the property
- Whether the insurance currently applied for is to be in addition to the current insurance, or will replace the current insurance
- Loss history in the prior three years
- Date of site inspection and place to attach site inspection report

The information on the commercial property application is used to determine the exposure to property risks of the property. Property coverage generally protects against the perils of fire, lightning, explosion, theft, windstorm, hurricane, hail, riot, civil commotion, smoke, aircraft, and land vehicles, as well as other perils as defined by the policy.

The location of the property is evaluated to determine its statistical risk of fire, windstorm, and other weather related perils. Location is also important in determining the risk of theft and vandalism. The type and value of personal property is also evaluated for the level of applicable risk exposures.

Site inspections are an important part of commercial property coverage and reports of site inspections may be submitted as part of the application. Site inspections are used to verify the type, condition and value of the property. Also from site inspections may come various underwriting requirements, such as requiring the installation of safety or security equipment.

Commercial General Liability Application

General liability and business owners liability forms cover certain types of liability, but exclude liability that arises out of professional acts (errors) or failure to act (omissions) while conducting professional services. The types of liability protection offered by a general liability or business owners liability form include bodily injury and property damage liability and personal and advertising injury liability.

These liability forms also cover medical expenses arising out of bodily injury on the insured's premises, or on the ways next to the insured's premises, or arising from the insured's operations. A general liability application generally includes the following:

- Description of the business premises and operations to be insured
- Type of business to be insured (individual, partnership, corporation, joint venture, limited liability company, non-profit or other)
- The name and phone number of person to contact for an inspection and audit of accounting records

- Description of management experience
- Number of employees
- Whether there is:
    - Exposure to flammables, explosives, chemicals?
    - Exposure to asbestos?
    - Exposure to radioactive materials?
- Whether operations involve storing, treating, discharging, applying, disposing or transporting of hazardous material (e.g., landfills, wastes, fuel tanks, etc.)?
- Whether sporting or social events are sponsored?
- Whether the business owns, hires or leases watercraft, docks, or floats
- Whether any operations have been sold, acquired, or discontinued in last five years
- Whether the applicant a subsidiary of another entity or does applicant have any subsidiaries
- Whether any machinery and equipment is loaned and rented to others
- Whether there is a swimming pool on the premises
- Whether parking facilities and owned or rented
- Whether a fee is charged for parking
- Whether the applicant has in force Workers Compensation coverage
- Whether subcontractors are used and if so, if certificates of insurance are required from all subcontractors
- Whether the applicant leases employees
- Whether the applicant plans any structural alterations to the property
- Whether recreational facilities are provided for employees
- Coverage and loss history
- Schedule of hazards and whether they are products/completed operations or premises/operations hazards

The application for commercial liability insurance is used to help determine the type and nature of liability risks to which the business is exposed. The rates to be applied to the application will vary based on the type of liability risks that exist. For example, a business that deals with hazardous materials will be charged higher rates than a business dealing with cardboard boxes or other non-hazardous materials.

The insurer may also need to amend or endorse their basic policy coverage based on the specific liability attributes of the business. They may need to add a pollution liability endorsement or a builders risk endorsement, for example.

Professional Liability and Errors and Omissions Application

Applications for professional liability and errors and omissions insurance can require very detailed, complete information. They may require specific descriptions of functions performed and the amount of time dedicated to each function. Past employment may have to be documented carefully. The reason for the thoroughness of the applications, especially for certain occupations, is the high amount of risk the insurer may be underwriting. The insurer wants to fully understand the scope of the risk being insured in order to charge appropriate premium, or in some cases, in order to refuse certain cases.

Name and Address

Each application includes the name and address of the applicant for the policy.

Type of Business Entity

The application also asks for the type of business entity - sole proprietorship, partnership, corporation, and so on.

Limit of Liability

The amount of coverage requested is listed. The applicant may be able to choose from a wide range of coverage amounts, from $100,000 or $500,000 in coverage to $1,000,000 or $5,000,000 or more.

Deductible

Deductibles may range from zero for lower limit policies to as much as $100,000 or more. Generally, the higher the deductible, the lower the premium charges will be. It is not uncommon for professionals who must carry high levels of expensive insurance, such as surgeons, to have a deductible of $100,000.

Professional Services Description

Each application will ask for some form of description related to the professional services involved. The application may include several possible functions involved in the occupation and ask the applicant to indicate which functions apply and what percentage of time is spent in or percentage of income results from each function.

For some occupations this portion of the application can be quite lengthy. An application for a lawyer may include fifty or more different types of law practices to which the applicant must assign a percentage.

Other Business Activity

If the applicant is involved in functions or activities not listed, these activities must also be disclosed and a percentage of time or income assigned.

Controlling Interest

The application may ask if the insured or other party has a controlling interest in the business.

Gross Revenue/ Projected Revenue

The application may ask for the amount of gross revenue which the professional or practice has earned. This helps the insurer and the agent to determine the appropriate amount of coverage. The insurer does not want the applicant to be covered by either too little or too much insurance.

Special Risks

If there are special areas of risk involved in an occupation, the application will include questions related to them. An application for a lawyer may ask about work related to securities transactions and whether the lawyer has any outside director or officer responsibilities. A physician's malpractice form may ask about certain types of surgeries or medical procedures.

Questions related to special risks and about important procedures in the firm or practice may also be included in the application. For example, record keeping is essential in many professions. The application may ask for details of the record keeping process within the business.

If fees are collected and money disbursed, the internal controls surrounding collection and disbursement may be inquired about. If a computer software risk is being underwritten, backup and other data safeguarding procedures may have to be explained on the application. The applicant should be as complete and accurate as possible when answering these items.

Years in Business

The insurer is interested in the stability of a business. The application asks for the number of years the business has existed. If the business is a new business, it may qualify for premium discounts. If it has been in existence for some time, the insurer is interested in knowing whether there has been continuous liability coverage in force.

Professional Qualifications

Another way in which the insurer assesses the risk of underwriting the professional or firm is by asking about the qualifications of the professionals being insured. Education, continuing education and any special credentials may be asked about.

Professional Associations

The insurer may be interested in knowing whether the insured belongs to any professional associations. Professional associations generally provide education and may require special standards of conduct in order to belong.

Use of Written Contract

If the applicant uses contracts to transact business, the insurer may ask questions related to limiting liability through contract language. As has been mentioned, some insurers reduce premium if liability is limited contractually.

Employees

The application will ask for information regarding the type and number of employees to be covered. This information may be used to determine the risk and related premium for employer liability and employment practices liability.

Contractors or Subcontractors

Certain forms may ask for information regarding the use of contractors and subcontractors. Forms for engineering firms, for example, may include questions related to subcontractors. The insurer may want to know whether contractors and subcontractors are required to carry their own liability policies.

Other Insurance

Other insurance currently in force which covers the liability of the professional is of interest to the insurer. Remember that the insurer wants to reduce the risk of moral hazard. The applicant should not have more insurance than is necessary for the risk to be appropriately covered.

Prior Insurance

Types and amounts of prior insurance are important information for the insurer. The insurer is interested in knowing if the insurance was occurrence based or claims based and if any extended reporting periods are in force.

Prior Claims

The insurer also wants details on prior claims. The insurer needs to be aware of any known exposures. If there is still exposure related to a prior occurrence, the insurer may attach an endorsement to the policy, specifically excluding claims related to that occurrence. The insurer will also ask whether the insured has knowledge of any act, omission or error that could result in a professional liability claim.

Legal or Disciplinary Action Against Applicant

If any applicant has had any legal or disciplinary action made against him or her, the details of the action must generally be disclosed to the insurer. If there are documents, such as copies of court orders or of a complaint, these are normally sent to the insurer along with the application.

Notice to the Applicant

Finally, the application will generally include a notice to the applicant. The notice requires the applicant to read the information and sign the application only if the applicant agrees to the representations made. The representations generally include that:

- The applicant declares that the answers in the application are true and that no material fact has been omitted
- The applicant has disclosed any matters which could result in a claim
- The form is an application and not a guarantee of insurance

The notice also generally includes the important statement that any person who knowingly and with intent to defraud any insurance company files an application with false information or conceals information regarding a material fact commits a fraudulent insurance act.

Special Coverages

If any additional coverages or endorsements are to be included, questions related to these coverages must also be completed on the application.

Inland Marine Personal Property Applications

Inland Marine Personal Property insurance, or personal property floater insurance, is often used to cover personal property in amounts greater than such property is covered through a homeowners policy. Such applications include the following information:

- Applicant name
- Applicant address
- Location of property (dwelling, apartment, condominium, mobile home, other)
- Occupation of members of the household
- Marital status of applicant
- Whether the location includes burglar alarms
- Whether the location includes any safes
- Security surrounding location if an apartment or condominium
- Whether property is located within one mile of a coast
- Whether the property is exhibited
- Whether the property is used in a business or commercially
- Where property is stored
- Loss history
- Coverage history
- Schedule of property to be insured, including:
    - Jewelry
    - Jewelry in Vault
    - Furs
    - Fine Arts
    - Cameras
    - Musical Instruments
    - Silverware
    - Stamps
    - Coins
    - Golfer's Equipment
- Direction to attach appraisals and bills that verify the value of the property to be insured
- Description of any property in mini-storage and description of storage facilities Personal property floater applications generally deal with valuable property. Often such applications must be accompanied by appraisal documents, bills and receipts that verify the property's value. Because the property is valuable, information regarding the safekeeping of the property is very important as well.

Ocean Marine Application

Ocean marine insurance is used to cover goods transported over the ocean and protects against perils of the sea. It is one of the oldest forms of insurance coverage. The application for such insurance may include the following:

- Name of the insured (often called assured in this form of insurance, and often a business)
- Address of the insured
- Type of business
- Type of cargo shipped and the percentage of each type as part of annual shipments. Type of cargo the insurer may ask may include:
    - General Merchandise
    - Branded Goods
    - Precision Instruments
    - Machinery
    - Bottled products, excluding beverages
    - Non-Perishable Food Items / Pharmaceutical Products
    - Bottled Beverages
    - Automobiles and other Motor Vehicles
    - Household Goods and Personal Property
    - Frozen Food (other than Frozen Meat)
    - Frozen Meats
    - Chemicals
    - Fine Arts, Antiques and Similar Items
    - Steel Sheets, Coils, Bars, Billets and Similar Items
    - Yachts
    - Computers, Mobile Phones and Similar Items
- Prior premium and loss history
- Primary shipment departure and arrival points
- Maximum value of any shipment
- Percentage of shipments representing full container loads, partial container loads and by breakbulk
- Percentage of shipments shipped by sea, air and by land
- Further explanation of any item on the application

Ocean marine coverage may be issued on a per shipment basis, or may be issued to cover all shipments from the insured. The latter method is used when an insured's shipments do not vary dramatically. If insurance is provided on a case-by-case basis, the details of the shipment must be scheduled, or listed, in the policy.

Workers Compensation Application

Workers Compensation applications are completed by the business that will provide the coverage for employees and generally include the following information:

- Name of the insured
- Address of the insured
- Type of business
- Years in business
- Total number of employees
- Number of full-time employees
- Number of part-time employees
- Number of employees under 18
- Number of employees over 65
- Number of employees who work from home
- Number of employees who drive employer-owned vehicles
- Whether the employer provide group transportation by employer-owned vehicles
- Whether the employer uses sub-contractors, and if so, the number of them
- Payroll information by class and payroll (typically based on regulating state statute)
- Excluded corporate executives (if state law allows the option for such people to be excluded from Workers Compensation coverage)
- Information related to workplace safety programs, such as:
    - Whether the business has a safety program
    - Whether safety meetings are held and if so, how often
    - Whether new employees participate in safety training
    - Whether injured employees are offered modified work
- Information related to the Workers Compensation claims process in place at the business Workers Compensation rates are based on job classifications and set by the state in which the Workers Compensation policy applies. Each job is assigned a classification code, and each code has a rate, with higher risk jobs being assigned a higher rate. The premium is based on each $100 of payroll multiplied by the applicable rate. Underwriters then often use a retrospective rating process to adjust rates each policy year. Also affecting rates is the utilization of rehabilitation. If an employer has a rehabilitation program which retrains employees or provides physical exercise and therapy, rates may be reduced by the insurer.

Medical Reports

Besides the application, the underwriters have other resources they may utilize during the underwriting process. For life and health insurance, the medical history of the insured must be examined. The application for the policy includes questions pertaining to basic medical information, including age, height, weight and health history of the applicant and the applicant's family.

Besides the application, if the coverage amount requested is above an insurance company's non-medical limit, additional medical information may be requested through a medical report. Generally, a medical report may be completed by a paramedic or a registered nurse. If there is information in the

application or medical report that requires further explanation, an attending physician's statement, or APS, may be required.

An APS must be completed by a physician who treated the medical condition under question.

Attending Physician Statement: An APS is a questionnaire sent to the applicant's doctor. The doctor must complete the questionnaire in order for the underwriters to complete the underwriting process. The proposed insured must give his or her permission on the application for the attending physician to provide this information.

An attending physician statement is a relatively simple document. It generally includes:

- Patient's (insured's) name
- Patient's address
- If related to an insured's employment, a statement for the physician to designate whether the patient is able to return to work, and if unable, when it is anticipated the patient will be able to return to work
- An area for the physician to indicate the physician's diagnosis and prognosis.
- An area for additional remarks for the physician
- The physician's name, license number, address, phone number and signature

The Medical Information Bureau: Besides medical reports and APS reports, insurers have access to medical information through the Medical Information Bureau, Inc. or MIB. The MIB is an association of most life and health insurers in the United States. The MIB contains information about the medical condition of applicants and insureds. Applicants must currently authorize the release of information to the MIB.

The information may only be used for underwriting and claims purposes, and medical information is released only to the applicant's physician, or directly to the applicant if the applicant requests. The Medical Information Bureau is considered to be an important tool of the insurance industry because of its role in reducing fraud. By keeping track of important pieces of information used in the application and underwriting of life, health, disability and long-term care insurance, it is more difficult for applicants to falsify applications and claims.
Reducing false applications and claims means that premiums do not have to be raised for everyone who purchases such insurance due to fraud that has been discovered through the use of the MIB.

Inspection, Consumer and Credit Reports

If an applicant applies for amounts of insurance above certain levels, the insurer may conduct inspection reports and/or acquire credit reports on the applicant. An inspection report is created from interviews with an applicant's neighbors, associates and employees, and sometimes with the applicant as well. The inspection report and interviews are conducted by national investigative organizations hired by the insurer. Insurance companies request inspection reports in order to get a better understanding of an applicant's overall character, lifestyle, financial situation and risks to which an applicant may be exposed.

Consumer Reports: Credit reports provide information about the financial condition of an applicant. This is important to an insurer because insurance involves a financial commitment from the policy holder. If an insurer accepts policies from people with poor credit, or credit below a certain standard,

policy lapses are likely to go up. Lapses cause an increase in expenses to the insurer who has incurred policy issue expenses associated with the policy.

Credit and consumer reports are regulated by the Fair Credit Reporting Act. This Act was originally enacted in 1970 and has been amended by other legislation since that time. It is important that agents understand the regulations applying to insurers from the Act so that agents are careful to follow the disclosure requirements that the insurer has put in place in accordance with these laws and so that agents can answer questions from customers asking to what use insurers are able to put these reports.

The Act regulates consumer reports and investigative consumer reports. Under the act a consumer report is defined as follows:

Consumer report:

1. In general. The term "consumer report" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumer's eligibility for:

    A. Credit or insurance to be used primarily for personal, family, or household purposes
    B. Employment purposes
    C. Any other purpose authorized under section 604 [§ 1681b]

2. Exclusions. The term "consumer report" does not include

    A. Any. . .
    B. Report containing information solely as to transactions or experiences between the consumer and the person making the report
    C. Communication of that information among persons related by common ownership or affiliated by corporate control
    D. Communication of other information among persons related by common ownership or affiliated by corporate control, if it is clearly and conspicuously disclosed to the consumer that the information may be communicated among such persons and the consumer is given the opportunity, before the time that the information is initially communicated, to direct that such information not be communicated among such persons;
    E. (B) Any authorization or approval of a specific extension of credit directly or indirectly by the issuer of a credit card or similar device
    F. (C) Any report in which a person who has been requested by a third party to make a specific extension of credit directly or indirectly to a consumer conveys his or her decision with respect to such request, if the third party advises the consumer of the name and address of the person to whom the request was made, and such person makes the disclosures to the consumer required under section 615 [§ 1681m]
    G. (D) A communication described in subsection (o).

The Act also defines “investigative consumer reports,” which the insurance industry generally refers to as “inspection reports:” The term “investigative consumer report” means a consumer report or portion thereof in which information on a consumer’s character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with neighbors, friends, or associates of the consumer reported on or with others with whom he is acquainted or who may have knowledge concerning any such items of information.

Such information shall not include specific factual information on a consumer’s credit record obtained directly from a creditor of the consumer or from a consumer reporting agency when such information was obtained directly from a creditor of the consumer or from the consumer.

Permissible Purposes of Consumer Reports: Under the Fair Credit Reporting Act, consumer reports may only be furnished for certain purposes by consumer reporting agencies. One of these permissible purposes is furnishing a report to a person the consumer reporting agency has reason to believe intends to use in connection with the underwriting of insurance.

Use of Consumer Reports: Under the Fair Credit Reporting Act, a consumer reporting agency may only issue a consumer report that is not initiated by a consumer request if the consumer authorizes the agency to provide the report or the transaction for which the consumer report is used is considered a “firm offer of insurance.”

If a consumer report is issued because the transaction is a “firm offer of insurance” and is not authorized by the consumer, the report may only furnish the name and address of the consumer, an identifier used solely to verify the identity of the consumer and other information pertaining to the consumer that does not provide the relationship of experience of the consumer with a particular creditor or other entity.

Items That May Not Be Included In Consumer Reports: Consumer reports initiated by the consumer or authorized by the consumer may not generally include:

- Bankruptcy that occurred more than ten years before the report
- Civil suits, civil judgments and records of arrest that were recorded by the greater of seven years before the report of the governing statute of limitations has expired
- Paid tax liens that were paid more than seven years before the report
- Accounts placed for collection or charged to profit or loss more than seven years before the report
- Any adverse information, other than records of convictions of crimes, that occurred more than seven years before the report.

Disclosing Investigative Consumer Reports: In order to have an investigative report prepared, it must be clearly and accurately disclosed to the consumer than an investigative consumer report, that includes information about the consumer’s character, general reputation, personal characteristics, and mode of living, may be made. The disclosure to the consumer must:

- Be in writing
- Be mailed or delivered to the consumer not more than three days after the date the report was requested
- Include a statement that the consumer has the right to request information about the nature and scope of the investigation.

If the consumer requests information about the nature and scope of the investigation, the person who caused the report to be prepared must comply with the consumer's request in writing not later than five days after the request was received.

Disclosures to Consumers: The Fair Credit Reporting Act and related legislation also requires that reporting agencies, upon request from the consumer, disclose:

- All information in the consumer's file at the time of the request, other than credit scores or similar risk predictors
- Sources of information, other than information used solely for an investigative consumer report which must be available if needed for the discovery process in an applicable court case
- The identity of each person who procured a consumer report generally in the last one year period only
- Dates, original payees and amounts of any checks upon which is based any adverse characterization of the consumer

A consumer reporting agency must also include a "Summary of Rights" with the disclosure to the consumer. A Summary of Rights includes:

- A brief description of the Fair Credit Reporting Act and all consumer rights within it
- An explanation of how a consumer may exercise rights under the Fair Credit Reporting Act
- A list of Federal agencies responsible for the enforcement of the provisions in the Act, including addresses and phone numbers
- A statement that the consumer may have additional rights under State law
- A statement that a consumer reporting agency is not required to remove accurate derogatory information from a consumer's file that is in compliance with the Act.

Disputed Information: If a consumer disputes the information from a consumer reporting agency, the consumer reporting agency must reinvestigate the information free of charge.

The consumer reporting agency must then record the current status of the disputed information or delete inaccurate information, generally within thirty days from the date the consumer reporting agency receives the notice of dispute from the consumer. In some cases, the consumer reporting agency can deny reinvestigation because it determines the request is frivolous or irrelevant. If information in a consumer's file is found to be inaccurate or unverifiable, the consumer reporting agency must promptly delete the item or modify it as applicable.

Special Restrictions On Investigative Consumer Reports: If a consumer reporting agency prepares a subsequent investigative consumer report on the same consumer, it cannot include any adverse information in the report, other than matters of public record, unless the adverse information has been verified during the process of making the subsequent report, or the adverse information was received within three months prior to the date the subsequent report is furnished.

Requirements for Uses Of Consumer Reports: The insurance company is a user of consumer reports and is subject to certain rules found in the Fair Credit Reporting Agency and related

legislation. Under these rules, if adverse actions are taken on the basis of information found in consumer reports, the insurer must:

- Provide to the consumer oral, written, or electronic notice of the adverse action
- Provide to the consumer orally, in writing or electronically the name, address and phone number of the consumer reporting agency that furnished the report along with a statement that the consumer reporting agency is unable to provide the consumer with the specific reasons the adverse action was taken
- Provide to the consumer oral, written or electronic notice of the consumer's rights to obtain a free copy of the report and to dispute the accuracy or completeness of information

Duties of Users Making Insurance Solicitations On The Basis of Information Contained in Consumer Files: Anyone who uses a consumer report in connection with an insurance transaction not initiated by the consumer and that is a "firm offer of insurance" must include with the solicitation:

- A written statement that information in the consumer report was used in connection with the transaction, that the consumer received the offer of insurance because the consumer satisfies the criteria of insurability for the offer
- A statement that, if applicable, the insurance may not be extended if the consumer does not meet the criteria of insurability
- A statement that the consumer has the right to prohibit information contained in the consumer's file with any consumer reporting agency from being used in any credit or insurance transaction not initiated by the consumer

The person who makes an offer of insurance based on a consumer report must also maintain on file the criteria used to select the consumer to receive the offer, all criteria bearing on credit worthiness or insurability that are used to select consumers for the offer, and any requirement for the furnishing of collateral as a condition of insurability for three years after the offer was made.

Site Inspections

Another valuable tool in the underwriting process is a site inspection. Site inspections are often used in commercial insurance, and may also be used in homeowners insurance underwriting. Site inspections involve inspecting buildings on the insured premises and noting what construction materials have been used, what safety devices, such as sprinkler systems or fire doors, are in place, the overall condition and upkeep of the property, whether there are any hazardous conditions present, and what type of personal property exists. Inspection of the premises may be done as part of a risk management process.

Commercial property and casualty insurers often include loss control or risk management in the underwriting process. The agent or risk management personnel employed by the insurance company may be responsible to conduct a thorough review of the business operations before insurance is issued. There are several different methods that can be used for systematically locating risks that may be reduced through risk management or loss control processes. Insurers often have checklists, called exposure checklists, which are available for use to locate risks in a business.

Another method used to identify risks is through the review of financial statements. Each item on the financial statements is analyzed in terms of risks that arise from that item. A third method is to identify

all business activities such as hiring, training, customer services, record keeping and accounting, and to identify the risks related to them. Actual losses can also be reviewed and the risks that led to each loss identified.

A fourth method is to use a flowchart of the businesses operations. A chart perhaps beginning with the receipt of an order through the receipt of payment for delivered goods, that follows the flow of the business from inventory management, processing and packaging of goods, as well as follow-up, may help to discover areas of risk that might be missed if a less thorough analysis were made.

A fifth method is to conduct interviews with managers, supervisors and the actual workers in each business area. Such interviews serve to familiarize the risk or loss control staff with business operations, and add to information found in written documentation about each business function. An inspection of the premises and the operations conducted within is often used to find and verify risks.

Once the inspection and interviewing process is done, the findings are reduced to a report, which is provided to the underwriting department. From the report, the underwriters are able to evaluate risks, and may include requirements, such as requiring certain safety devices to be installed, safety training to occur, and so on, in order to issue a policy.

Insurance Maps

Insurance maps are special maps that include risk information based on location. An insurance map may be designed for use to determine the risk levels related to automobile accidents, automobile theft, property theft, exposure to damage from windstorms or flood, fire, and so on. These maps are used by underwriters to determine the risks associated with the location of property and the territory in which it is used, and therefore to assign the rate appropriate to the risk. Insurance maps may not be used in conjunction with unfair discrimination in redlining, as will be discussed in the next chapter.

Company Records

An insurer will use its own company records as a resource for specific information about the applicant and for general loss statistics related to similar risks. An applicant may have policies in force from the same insurer underwriting the new application. If so, the underwriters will check the information on the existing policies to see how they compare to the information on the current application. The underwriter also wants to determine the total coverage an applicant has with the insurer.

Insurers establish certain maximum coverage levels they will provide for a certain risk or a certain applicant. The company's loss statistics pertaining to the type of risk being underwritten are also used by the underwriters. An insurer must not have too much exposure to any certain risk. If an application represents a potentially high level of exposure for an insurer, the underwriter may look to reinsurance as a way to reduce its own exposure.

Insurance Industry Statistics and Reports

The National Association of Insurance Commissioners and Insurance Services Office, Inc. are two important sources of insurance industry statistics and reports. There are other organizations, such as the Risk and Insurance Management Society, Inc., the Inland Marine Underwriters Association, the Health Insurance Association of America, the Insurance Research Council, the National Association

of Health Underwriters, and many, many more, that provide research, statistical data and reports for various types of insurance.

Underwriters utilize this data in determining the appropriate rates to charge for applicants. Often this type of data is used when standard rates and manual rates are determined, on both the state and insurance company levels.

Hazards: The underwriting process may involve reviewing many of the resources just identified. The application, reports such as medical reports, consumer reports, credit reports, site inspection reports, and financial statements, and insurance maps, company files and industry statistics are all evaluated.

One of the purposes of the evaluation is to determine whether the application includes indications that there may be certain hazards inherent in the risk to be insured. A hazard is the term used to describe conditions that increase risk. Insurers are generally concerned about three types of hazards: moral hazards, morale hazards and physical hazards.

Moral Hazard: When used by an insurer, the term moral hazard means a condition or conditions that increase the likelihood that an insured or a person in a position to be paid by an insurer will intentionally cause, overstate or increase a loss. When insurance is used to manage a risk, the insurer takes care to make sure that the amount of the insurance coverage issued is not excessive.

Excessive coverage can contribute to moral hazard. In addition, the insurer may require an applicant to authorize a credit check or other financial review by the insurance company to make sure the applicant is financially healthy. Such financial checks are undertaken to reduce the likelihood that the insurer issues a policy to someone likely to falsify a claim due to financial pressures.

Morale Hazard: A morale hazard is a condition or conditions that increase the likelihood that the attitude of the insured or a person who will be paid by the insurer will cause a loss. For example, once an item or operation is insured, it is possible that its owner will be less prudent concerning it. For this reason, insurers require safeguards in order to insure certain types of property or operations.

A property insurer may require that sprinklers and smoke alarms are installed in a building. A liability insurer will include a question on an application asking if required continuing education hours are maintained. A crime insurer excludes any person who has ever been discovered to have committed a dishonest act from Employee Dishonesty coverage. All these actions are attempts to reduce morale hazards.

Physical Hazard: A physical hazard is a condition or conditions of property, people, or operations that can increase loss. For example, a construction site that allows access to structurally incomplete and unsound buildings increases the possibility that someone who wanders onto the site will be harmed. Insurers are interested in eliminating as many applicable physical hazards as possible prior to insuring a property, a person, or an operation.

Underwriting Decision: Once all the factors are weighed, an underwriting decision is made. The application will either be accepted as a standard risk, a substandard risk, a preferred risk, or will be rejected. Any application that is accepted may include underwriting requirements that must be fulfilled in order for the insurance to apply.

The Role of the Agent in the Underwriting Process

The agent is crucial in the underwriting process. Agents are often referred to as field underwriters, or even simply as underwriters. This is because they gather underwriting information, evaluate risk, often do a preliminary assignment of premium, may authorize preliminary coverage, and may reject applicants on behalf of the insurer. During the underwriting process, the agent is often responsible to gather additional documentation and information to assist the home office underwriting team.

Suitability

An important part of the agent's function in underwriting is determining a suitable financial product for the client. Agents involved in offering life insurance and health insurance products are most affected by the requirements and processes involved in suggesting suitable products.

Many elements are included in determining a client's suitability. These include the age of the client, the tax status of the client, what type of investments the client already owns, the investment objectives of the client and the net worth and overall financial health of the client.

Determining Client Needs

Often the insurance company the agent represents provides procedures and forms to aid in determining a client's needs. Depending upon the types of products the agent offers, the needs analysis or fact-finding process may be relatively simple, or it may be very detailed.

Basic Information: The first part of a needs analysis generally focuses on basic information about the client. The agent will ask for the client's full name, address, occupation, marital status, number and age of minor children, and age of the client, for example. This basic information can help the agent begin to see certain potential needs of the customer.

For example, the marital status of a client may indicate a need to protect loved ones from financial loss. The age of a client can indicate that a client is nearing retirement or at an age when long-term care planning is prudent. The occupation of a client may indicate that he is likely covered by a healthy benefits plan or they he may need full or supplemental coverage. However, the agent needs more information before the agent may make any judgments about potential product needs.

Financial Information: After basic information is gathered from the client, the agent must ask for financial information. Sometimes a client is hesitant to give this information to the agent. If so, the agent may explain that client information is held confidentially and that the agent has a responsibility to the client to understand his or her financial situation in order to give the best advice possible. If a client absolutely will not provide financial information, generally the agent should explain to the client that the agent would have to suspend the interview until the client is willing to provide this information.

Trying to assist a client with a life insurance product without knowledge of the client's financial situation can compromise the agent's fiduciary responsibilities to the client. Generally, the agent will need to know the client's net worth. The agent may ask for an item by- item list of the clients' assets and liabilities, or may just ask for a net worth figure from the client. The agent will also ask for the client's monthly income earned from his or her occupation, and the amount of income the client receives from any other source. Another critical piece of financial information is the tax status of the client. The agent will generally find out whether the client is in the 15%, 28%, 36% or higher tax bracket.