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Planning Life & Health Needs

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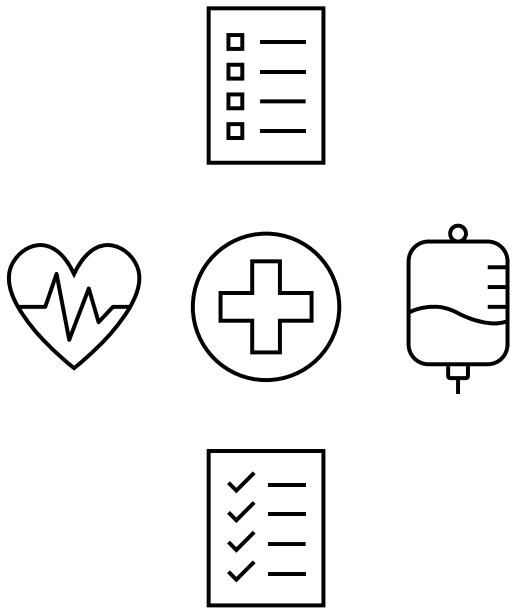

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PUBLISHER'S NOTE

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SECTION I: PENSION PLANNING OVERVIEW

Qualified retirement contributions can be made with various investment options when developing a pension plan within one's insurance policy.

These qualified plans are generally not subject to current taxation when they are contributed to through the plan.

Be sure to recognize that change is inevitable, and a person must be flexible when considering life insurance and annuity contracts to enhance their financial security.
To retire someday at 100 percent of someone's standard of living, they will have to take advantage of Social Security, their employer's qualified retirement plans, and save 20 percent of their gross income each and every year. There is no better way to begin this personal accumulation pattern than by participating at the maximum level possible in the employer-provided plan that allows one to invest with pretax dollars.

A pension plan provides the simplest, most readily available method for deferring taxation on investment earnings. Pension plans are probably the largest category of deferred tax plans offered by private corporations and public organizations.

Employee pension funds in American industry date back to the Civil War, if not earlier. Starting in the mid-1930s, pension commitments made by employers to employees became increasingly significant in business and industry. By 1950, there were some 2,000 funds in operation.

It is not uncommon for an individual's largest single asset to be the vested interest in a pension or retirement plan. On average, retirees can expect their retirement income to be from 55 to 70 percent of their employment income, with after-tax dollars, derived from personal savings, pension plan(s), and Social Security.

Social Security was established as a pension plan, but it has never functioned as such. Instead, it has been a program of transfer payments. In 1937, the Social Security Board printed posters that read, "There is no guarantee that the funds thus collected will ever be returned to you. What happens to the money is up to each Congress."

In today's pension plans, what happens to the money is up to the employee, the employer, the pension fund manager or trustee, or a combination of these.

A pension plan itself isn't an investment. It is a legal arrangement for holding investments that provides certain tax advantages.

The Five Common Elements of Pension Plans:

1. Subject to certain qualifications and legal limits, money put into the plan can be deducted from the taxable income of the person putting it in, whether an employer, employee, or both.
2. Nondeductible contributions may be permitted in some cases, but not in unlimited amounts.
3. The plan pays no taxes. Interest, dividends, and capital gains accumulate and compound tax-free as long as they stay in the plan.
4. Money coming out of the plan is taxed, except for the return of contributions to the plan that weren't tax-deductible when they were made.
5. There is a penalty for withdrawing money from the plan "prematurely," which generally means withdrawing money before a participant reaches age 59 1/2.

There must be a formal, written document covering the plan, and it must satisfy the requirements of the applicable Internal Revenue Code.

Terminology

Accrued Benefit

The benefit a plan participant has accumulated up to a particular point in time.

Actual Deferral Percentage

(For the eligible highly compensated employee and all other eligible employees for a plan year.) The average of the ratio, calculated separately for each employee in such group, of the amount of employer contributions paid under the plan on behalf of each employee to the employee's compensation.

Covered Employees

Those employees in any year whose accounts are credited with a contribution under the plan for that year.

Death Benefits

The amounts payable under many private pension contracts to the employee's heirs should they die before beginning to draw a pension.

Eligible Employee

An employee who, in any year, is eligible for employer contributions under the plan for that year.

Funding

Building up actuarially adequate reserves, based on actuarial assumptions on the life expectancy of participants, on interest rates, and on future pension levels.

Guaranteed Payment Period

In some contracts, a guarantee of 10, 15, or (rarely) 20 years of pension payments, whether the pensioner survives or not.

Highly Compensated Employee

An eligible employee who receives more compensation than two-thirds of all other eligible employees.

Past-Service Liabilities

The funding obligation for the pension claims of employees who were already on the payroll when the pension fund started and who, under most contracts, are entitled to a full pension even though nothing was paid into the fund for them in earlier years. Every increase in pension benefits—for example, a rise in wages—creates a new set of past-service liabilities for employees already on the payroll, which, under ERISA, have to be funded over a period of years.

Pension Plan

A legal arrangement for holding investments that allows the income and profits from investments to accumulate tax-free until money is withdrawn from the plan.

Tax Deferral

The delay of the date when income will be recognized for tax purposes.

Vesting

Achieving participation in a plan. A vesting schedule spells out the years of service an employee needs before being entitled to a pension, either a full pension or a fraction of it.

There are three types:

1. **Cliff vesting**—100 percent vesting after 10 years of service, with no vesting before completion of 10 years of service.

2. **Graded vesting (5 to 15 years)**—25 percent vesting after five years of service, plus 5 percent for each additional year of service up to 10 years (50 percent vesting after 10 years), plus an additional 10 percent for each year thereafter (100 percent vesting after 15 years of service).

3. **Rule of 45 (based on age and service)**—50 percent vesting for an employee with at least 5 years of service when their age and years of service add up to 45, plus 10 percent for each year thereafter.

Defined-Benefit Plans

Defined-benefit plans commit employers to pay a certain benefit amount when an employee retires. The benefits are based upon employee's age, years of service, income during employment, as well as other factors. The amount is predetermined and guaranteed.

The annual pension cost is based upon a formula that consists of a percentage rate times the number of years of service, multiplied by the income at the year of retirement, or an average of several years' income. The expense of a plan for the employer is based on the estimates of the benefits to be paid. Employer and employee contributions to the plan and accumulated earnings from plan investments are estimated to pay the benefits as provided in the plan.

These plans have fallen out of favor because they require employers to pay out a certain amount upon retirement, regardless of how the investments did during working life. If the investment fails, the employer has to make up the difference.

Defined-benefit plans are federally insured.

Defined-Contribution Plans

Defined-contribution plans have been growing in popularity. These plans commit the employer to contributing a certain amount each year (either a percentage of the company's income or a percentage of the employee's income). Once the defined contribution is made, the employer has no other pension liabilities.

The pension expense for the year is the amount of contribution that is made to a third-party trustee. Because the contributions, as they accumulate, belong to the employee, the employee assumes the risk of poor investment performance. However, they also share in the profit gained from wise investment management, through an increase in future pension benefits. Employees may be responsible for choosing what they want their contributions invested in. Options can range from company stock to fixed-income securities.

The only definite figure in this sort of plan is the amount of money invested, not the amount of money that will be received. The benefits are based on the level of the defined contributions and the earnings of the plan's investment portfolio.

Types include:

- Stock-option plans, which either give employees stock in the company or give them opportunities to purchase shares.
- 401(k) Plans.
- Individual Retirement Accounts, the most common form of personal retirement planning. IRAs allow an individual to contribute a maximum amount to a tax-deferred account.

Contributions are permitted under two circumstances.

- First, if an individual or married couple has an adjusted gross income below a specified phase-out level, contributions can be made.
- Second, if neither a single individual nor either party in a marriage is an active participant in an employer-maintained retirement plan for any part of the plan year ending with or within the individual's taxable year, contributions can be made. The money contributed annually can be deducted from taxable gross income either entirely or partially, depending on income. An employer can also sponsor IRAs.

Keogh plans, which are similar to IRAs, are tax-sheltered pension plans for self-employed individuals or partnerships. Keogh plans escaped virtually unscathed from the federal tax code overhaul in 1986.

There are two types:

1. profit-sharing or
2. money-purchase.

Annual contributions to a Keogh plan are basically limited to 25 percent of self-employment earnings or $30,000, whichever is less. The IRS has different guidelines for self-employed people, employees, and business owners.

Keoghs have one big advantage over IRAs: When money is withdrawn from them (after age 59 1/2), forward averaging can be used to ease the tax bite.

Profit-sharing plans allow the company's profits to help finance individual employees' retirement benefits. A designated percentage of company profits is added to employee contributions, which then go into a trust fund that will finance retirement benefits.

The portion of the employer's contribution to the plan that goes into an individual employee's account is usually tied to wages. A profit-sharing plan need not provide retirement benefits.

The following provides a comparison between profit-sharing and pension plans.

Choosing Between Pension and Profit-Sharing Plans

Other Types of Plans

A Qualified Plan gives the employer certain tax benefits. The benefit to the plan participant is a deferral of taxes on the benefits until they are received in retirement. The employer's contribution to the plan can be deducted when made to the fund. Earnings of the fund are not taxed until they are distributed to beneficiaries years in the future.

A Funded Plan's assets have been transferred to a trustee. If the total amount recognized as an expense has been given to the trustee, the plan is fully funded. If only a part of the expense has been recognized, the plan is a partially funded one.

An Insured Plan transfers the risk of future commitments to an insurance company. The employer funds the plan by purchasing an annuity contract from an insurance company, with the insurance company contracting to pay the defined benefits as they come due. The company agrees to contractual premium payments.

An Unfunded Plan does not require the company to transfer funds to a third-party trustee. Such plans can be thought of as pay-as-you-go plans. There is a significant accounting aspect to these plans; for example, funding takes place when the benefit is paid to the retiree, so no pension expense is recognized during the years of the employee's employment.

SETTING UP A PENSION PLAN

In most cases, setting up a pension plan is easy. Almost any bank, savings and loan association, mutual fund, stockbroker, or insurance company will sponsor or provide various ready-made plans. Usually, a plan sponsored by a financial institution allows one to invest only in the investments the sponsor handles.

Individuals can be eligible for more than one type of pension plan, as long as their annual contributions, taken together, do not exceed the legal limits. Plans can be kept at different institutions.

Companies may have more than one plan. Actuarial methods may differ, but accounting for each plan should follow the stated standards.

It is not possible to set up a pension plan outside the United States.

Once an employer sets up a pension plan, all employees must be allowed to participate in it. Under most circumstances, any employee over the age of 21 who has worked at the company for one year is eligible. (To get credit for a year of service, an employee must have worked at least 1,000 hours in the previous 12 months.)

There are exceptions. An employer can require employees to be with the company for two or three years before granting eligibility for participation in the plan, if, when they join the plan, their right to their benefits becomes 100 percent vested immediately. Another exception applies to tax-exempt educational institutions, which can require employees to be at least 26 years old to participate.

Pension plans may not exclude an employee solely based on part-time or seasonal employment if the employee has a year of service (as defined above). Plans of the maritime industry may designate 125 days as constituting a year of service. In the case of a seasonal industry where the customary period of employment is less than 1,000 hours during the year, a year of service is to be defined by regulation.

Participation cannot be denied to an employee because they begin employment late in life, if the plan provides defined contributions such as profit sharing, stock bonus, or money purchase plans. Plans defining benefits are permitted to exclude an employee who begins employment within five years of the plan's normal retirement age. However, for plan years starting on or after Jan. 1, 1988, employers cannot exclude from plan participation any employees who start work within five years of a plan's normal retirement age.

A "floating" normal retirement age that could be no later than the fifth anniversary of the employee's participation in the plan could be established.

Planning Process

A qualified plan obtains advantageous tax treatment by meeting the requirements of the code and the regulations and rulings issued by the IRS. Receiving pension benefits seems straightforward. Once people turn 591/2 years old, they may receive the money in their pension plans. If they want their money before reaching age 59 1/2, they face a 10 percent tax penalty.

There are several exceptions in which the penalty is waived, including:

- If a person becomes disabled and thus is unable to work.
- If the person is at least 55 and retires or otherwise leaves the company. This is called "separation of service" by the IRS.
- If a person quits, retires, or otherwise leaves the company, and receives the pension payout in a series of scheduled payments over their life expectancy (or the joint expectancy of the person and their designated survivor).

- The amount of payments can be determined by checking a life expectancy table, such as the IRS table in Publication 575. These payments must be roughly equal and must be paid at least annually. Payments must be received for at least five years.

- If the schedule is changed so it doesn't qualify for the exception or is switched to get a lump sum distribution, a "recapture tax" must be paid.

Plan Funding

Funding a plan means building up actuarially adequate reserves, based on actuarial assumptions on the life expectancy of participants, on interest rates, and on future pension levels.

Plans are generally funded by employee contributions, employer contributions, and earnings from investments, which can range from company stock to mutual funds to fixed-income securities. These investments may be chosen by either a plan trustee, a manager, or the participants themselves. Contributions vary; they may be a percentage of the company's income or a percentage of the employee's income.

Participants of certain pension plans are protected by federal law from financing that is inadequate to pay the promised benefits.

For defined-benefit pension plans, ERISA requires employers to annually fund the normal cost; that is, the pension benefits earned that year by the employees. Formulas are established for amortizing the past service liabilities and the cost of retroactively raising the level of benefits by plan amendment and for making up experience losses and changes in actuarial assumptions.

In order to make underfunding as unprofitable as possible, ERISA provides severe sanctions. Unless a waiver is obtained, any failure by the employer to comply with the minimum funding requirements will result in an excise tax on the amount of the accumulated funding deficit. This tax is imposed whether the underfunding was accidental or intentional. The tax, which is not deductible, is imposed for each plan year in which the deficiency has not been corrected.

These funding rules do not cover profit-sharing and stock bonus plans. They apply to money purchase plans only to the extent of requiring that the employer contribute the amount specified by the plan formula. Pension plans funded exclusively by the purchase of certain insurance contracts, which satisfy certain conditions, are exempt from the funding requirements.

Taxes and Benefits of Qualified Plans

Over the years, the types of fringe benefits offered to employees have evolved as methods of helping employees avoid or delay the impact of individual income taxes. At the same time, the government has effectively paid about half of the costs, because for every corporate deductible expense dollar, there is the corresponding maximum federal tax saving of 46 percent, plus any state tax savings.

A pension plan provides:

- Tax deductions for some or all of the money contributed to the plan.

- Tax-free accumulation of everything the plan's investments earn.

The employer gets a current deduction for amounts contributed to the plan, within specified limits, although no benefits may have been distributed to the participating employees that year. This allows an employer to accumulate a trust fund for their employees with 100-cent before-tax dollars, which, in effect, represent 54-cent after-tax dollars to the employer in the 46 percent tax surtax bracket. The employer expense for the contribution to a qualified plan may be accrued at year-end, but it must be paid no later than the legal time of filing the return (including extension).

The tax of the employee is deferred until the benefits under the plan are distributed or made available to them. If the employee receives a lump-sum distribution, a portion of it may be capital gains (based on years of participation before 1974), and the remaining taxable portion is subject to ordinary income rates. There is a special 10-year averaging option available.

Pension payout recipients are liable for a 15 percent excise tax if the combined payout of all their retirement plans, including qualified pension plans, profit-sharing plans, IRAs, and Keoghs, is more than $250,000 annually, or a one-time lump sum distribution of more than $750,000 from retirement plans is received. The 15 percent tax is applied to the total amount over the limit.

But there is a loophole: According to federal law, if at least $562,000 in retirement benefits was accumulated before August 1986, the funds can be grandfathered, allowing receipt of a lump sum payment that won't be subject to the excise tax. This election should have already been made on the recipient's 1988 income tax return (Form 5329).

A lump sum distribution can be rolled into an IRA if the money represents at least 50 percent of total pension benefits, all of the distribution is received in a single tax year, and the distribution is being paid because the pension holder retired, quit, became disabled, or died.

If the recipient needs the money immediately and cannot roll it into an IRA, five-year forward averaging may be useful. Forward averaging allows the pension holder to act as if the distribution is the only income received for the year and was spread over a five-year period. The entire tax is paid on the sum in one year, but the tax is at a lower rate than if it were taxed as regular income.

This technique can be used if:

- The pension holder has been a participant in the pension plan for at least five years.
- The lump-sum distribution received is from a qualified retirement plan—pension, profit sharing, or stock bonus—and represents 100 percent of the money in the plan.
- The money will be paid within a single tax year.
- The pension holder is 591/2 years old or older. There is an exception to this rule for people who were 50 or older on Jan. 1, 1986. Individuals born before 1932 can use five-year forward averaging with no penalty. Those born between 1932 and 1935 can use forward averaging but must pay a 10 percent penalty on the total.

The income and gains on the sale of trust property of the trust fund are exempt from tax until distribution. Funds, which are compounded tax-free under a qualified plan, increase at a much greater rate than if such funds were currently distributed to employees and personally invested by them. In the latter case, the amount received by the employee is subject to two tax bites—when they receive the benefits and again on the investment income earned on what is left.

FASB Statement of Financial Accounting Standards No. 35, "Accounting and Reporting by Defined Benefit Pension Plans," sets forth the standards for pension fund accounting. It applies to all defined benefit plans, except terminated plans. FASB No. 35's primary objective is to provide all the information necessary to determine the soundness of the plan, that is, the resources necessary to meet the future obligations of the plan.

The requirements are as follows:

- Accounting principles not included in the statement do apply.
- Information about the assets available to pay benefits, the participants' accumulated benefits, the plan's investment performance, and all other factors that may affect the plan's ability to pay accumulated benefits is disclosed.
- Statement of net assets available for benefits is disclosed.
- Information giving the present value of accumulated benefits and concerning significant changes in them is disclosed.
- The accrual basis of accounting is disclosed.
- Fund investments are disclosed at their current value.
- Operating assets, if any, are disclosed at their cost less accumulated depreciation.
- Changes in the current value of investments since the last reporting period are disclosed.
- Investment income is reported.
- Contributions from employers and employees are disclosed. Benefits paid since the last statement date are disclosed. Administrative expenses are reported.
- The actuarial present value of accumulated plan benefits attributable to employee service prior to the benefit valuation date is disclosed.
- Measurement rules for accumulated benefits and the basis for the calculations should be explained.
- Cost-of-living adjustments included in the plan should be disclosed.

FASB No. 35 and FASB No. 36, "Disclosure of Pension Information," both contain a number of actuarial and present value computations related to various aspects of a plan, including probability of payment, withdrawals, disability, rates of return, discounting future cash flow, vested benefits, nonvested benefits, and current investment values.

An important tax factor that must be considered by the employer and the statement preparer is the timing of actual payments into the pension or profit-sharing fund. All claimed expenses must have been disbursed (not merely accrued) by the legally required tax-return filing date, including all permissible extensions. A late filing of an 1120, without extension, would bring about disallowance of the claimed expense contribution to a pension plan if the payment had not been made by March (calendar year taxpayer). Preparers of financial statements should be aware of the possibility of a "subsequent event" disclosure.

Employee Stock Ownership Plans (ESOP)

ESOPs are classified as pension plans under the Employee Retirement Income Security Act (ERISA). The primary difference between ESOPs and most pension plans is that the assets of the plans generally consist of employer stock. ERISA authorized the creation of ESOPs as one method of encouraging employee participation in corporate ownership. The value of a benefit in an ESOP is directly related to the value of the stock of the employer.

ERISA

The Employee Retirement Income Security Act of 1974, better known as ERISA, requires those who establish pension plans to meet certain standards. Its main objective is to protect workers' pension rights, specifically the rights associated with funding, participation, and vesting. Its passage also changed the tax and information forms that employees must file with the IRS (and in some cases with the Department of Labor). ERISA was amended in 1984 by the Retirement Equity Act (REA) and in 1986 by the Tax Reform Act (TRA). REA provides additional protections for spouses of participants and liberalizes ERISA rules on participation and vesting. The rules are further liberalized by the TRA.

Title I of ERISA describes participants' rights. Exempt from Title I are governmental plans, certain church plans, plans maintained solely to comply with workers' compensation, unemployment compensation, or disability insurance laws, plans maintained outside the United States primarily for nonresident aliens, and excess benefit plans that are unfunded.

ERISA requirements affect employers' costs in the following ways:

Annual funding is no longer discretionary. A plan must be funded based on an actuarial cost that, over time, will be sufficient to pay all future pension obligations.

Tax deductions for the employer are not allowed, and fines are imposed by the government if plans are not funded in compliance with ERISA requirements.

Comprehensive terms of a pension plan and detailed annual reports and schedules must be published.

All reports, schedules, statements, and other required information are subject to audit by independent Certified Public Accountants.

Public Disclosure Materials Available

As mandated by the law, the Pension and Welfare Benefits Administration in the U.S. Department of Labor operates a public disclosure facility. Materials available include: V Annual reports—Submitted by plans and containing information on their operating characteristics and financial condition. The report consists of:

- Form 5500, filed annually by plans covering 100 or more participants.
- Form 5500C, filed every third year by plans covering owner-employees and having fewer than 100 participants.
- Form 5500R, filed for each year for which a Form 5500C is not filed.
- Schedule A, which provides insurance information and is included in plans with benefits provided through an insurance company or service.

- Schedule B, which provides actuarial information and is included by defined-benefit plans subject to the minimum funding standards.
- Schedule C, which provides certain information on service providers and trustees and is filed by plans with 100 or more participants.
- **Summary plan description**—Explains plan provisions in easy-to-understand language, including eligibility requirements, benefit levels, and the circumstances in which benefits may be lost. Employee benefit plans, with some exceptions for welfare plans, distribute this document to participants and submit it to the Department of Labor. Summaries of any changes in the information also must be distributed and submitted to the Department.
- **Master trust reports**—Filed annually with the Department by, or on behalf of, plans participating in a master trust. This report shows each participating plan's proportionate share of the assets, liabilities, income, expenses, and changes in the net assets held in the investment account(s) of the master trust.
- Common trust, collective trust, or pooled separate account direct filings—Filed annually on behalf of plans participating in a common or collective trust maintained by a bank, trust company, or similar institution, or a pooled separate account maintained by an insurance carrier that is federally- or state-regulated. This report shows the statement of assets and liabilities of the trust or account and identifies the participating plans.
- Apprenticeship and other training plan notices—Identifies the name and place where employees can get information about courses offered by the plan.
- **"Top Hat" plan statements**—A declaration that the employer maintains a plan or plans primarily to provide deferred compensation for a select group of management or highly compensated employees.
- Advisory opinion letters—Interpret and apply ERISA to specific factual situations and are issued by PWBA in response to written requests for opinions by their assigned number.
- **Comment letters**—Present views from the public on ERISA regulations and exemptions from the prohibited transaction provisions proposed by the Department of Labor.
- **Announcements and transcripts**—Over hearings held on ERISA regulations and meetings of the Advisory Council on Employee Welfare and Pension Benefit Plans.

Materials may be ordered from the Department in person, over the telephone, or by mail.

IRAs, Simplified Employee Pension Plans (SEPs), Annuities

IRAs that qualify for income tax deduction are qualified plans, simplified employee pension plans (SEPs), tax-sheltered or tax-deferred annuities (TSAs), 40l(k) plans, profit-sharing plans, and pension plans.

Besides enjoying the tax deferral on the earnings within these plans, the employee as well as their employer may also make capital investments into these plans without having to pay taxes on the amount of investment in the year of contribution. Because a person has not paid taxes on the amount contributed to the plan, they do not establish a cost basis.

These qualified plans are usually among the best investment opportunities available. Even with marginal tax brackets, the tax advantages of these plans are difficult to beat.

An employer may encourage an employee to invest in these plans by offering to match, for example, 50 percent of the employee's contribution. A strong net worth statement allows someone to pursue more opportunities than a weak one will. If someone would like to retire someday at 100 percent of their standard of living, they will have to take advantage of Social Security, their employer's qualified retirement plans, and save 20 percent of their gross income each year.

That task may seem formidable, but there is no better way than by participating at the maximum level possible in the employer-provided plan that allows employees to invest with pretax dollars.

One unique feature of qualified plans is that a person is required to begin payouts from these plans, or the annuities that hold the cash in these qualified plans, in the year in which they turn age 73. With non-qualified annuities, the basic objective is to continue deferral of annuitization as long as possible in order to maintain flexibility and to continue to compound the earnings within the contract without current taxation.

The present Internal Revenue Service regulations requiring someone to start making withdrawals from all of their qualified plans at age 73 do not change this basic strategy. In order to comply, it is not necessary to annuitize one's contract.

The case is even better for those with qualified plans who elect to make withdrawals from their plans on a joint and last survivor basis because the table for this type of distribution requires an even smaller amount to be distributed.

Failure to make the required withdrawals will expose someone to substantial penalties from the IRS, so make sure to check with a tax advisor.

The deferral to April 15 is available only for first-year distributions. In all succeeding years, distribution must be made within the calendar year. Be cautious in minimum distribution planning—to take less than the minimum exposes one to a 50 percent penalty on the amount that should have been withdrawn but was not.

Annuities are policy contracts that agree to pay the insured a regular income over a specified period of years. When an individual purchases an annuity policy, they agree to pay the insurance company a certain amount of money in exchange for this income.

The period over which the insurance company promises to provide income varies.

The contract may specify an exact number of years or the individual's lifetime—an unspecified number.

The term annuity usually refers to the contract made between an individual and an insurance company; it is also used to describe the income that the individual receives under the contract.

Annuities today can be an extremely efficient asset accumulation vehicle for retirement. Taxes on the interest earned on annuity contracts are deferred and are paid when distribution of the funds takes place. Therefore, this type of investment is often referred to as a tax-deferred annuity.

However, some investment counselors suggest that one should avoid annuitization until such time as it is the only remaining viable economic solution. If one decides to consider annuities, be sure to carefully examine the expenses in the contract, its limitations, the variety of accounts, the service, reporting, management, and the company's reputation.

A Rollover IRA Retirement Strategy

The rollover IRA is gaining popularity as an option for the disposition of retirement plan funds because it puts the retiree in control of the funds instead of the former employer. It also avoids current income taxation and provides for the continuation of tax-deferred earnings.

These funds have been accumulated over a lifetime of work and are considered core assets that should be managed more carefully. If someone lives on only the income from the capital they have in their rollover IRA and never invades principal, that person will be better off than if they had annuitized. If one can live on less than the income generated within the IRA, that person will see their capital increase.

This is highly satisfactory, both because one is better off each year and also since one's capital base is increasing each year, which will result in more capital being available to generate income. Someone may be looking for a way to make reinvested earnings work as hard as they can to offset inflation risks.

One way to do this is to dollar-cost average the excess earnings from a guaranteed principal and guaranteed interest account holding a person's core assets into one of the common stock accounts in the family of funds available within their rollover IRA contract.

This provides for some diversification and, with time and patience, often positive investment results. When these earnings become significant, they may be swept back to the safe haven account in which one's core assets are held. This builds up a person's "safe" account, which then generates more interest that can be used to increase the amounts being dollar-cost averaged into the stock account. The more earnings someone receives, the more earnings they generate.

Many conservative investors find this a very comfortable method of managing their rollover funds. It enables them to enter the stock market when they would not have been able to do so otherwise and thereby earn greater returns than they could with compound interest. It also increases diversification and allows the retiree to maintain control.

SECTION II: LIFE INSURANCE AS AN INVESTMENT

Life insurance can be a wonderful investment. A person's employer is a good source for satisfying their insurance needs.

Term insurance plans contain the two basic elements of this type of insurance — mortality and expense charges. As a result of paying these charges to an insurance company, a person's resources will be pooled with other policyowners to pay a death benefit to their beneficiaries. Different forms of insurance vary according to how these mortality and expense charges are paid. The first generic form of life insurance is term insurance.

Term insurance is protection against the risk of dying, and with it, one pays just what is required to cover the mortality and expense charges.

The "term" in term insurance indicates the period during which the premium remains constant. When someone renews a term policy, the premium will usually be higher for the next term. This is because that person is older at the time of renewal.

The premium for a term insurance policy is based on a person's age, health, whether they smoke, and the amount of coverage. Term insurance prices are easier to understand than other life or "plus" insurance policies. One simply pays a specified price for each $1,000 of death benefits, and it often is advantageous to buy larger amounts.

With term insurance, the death benefit is paid if the insured dies during the policy period. The term can last one year, five years, or ten years.

Renewable term insurance means that the policy can be renewed at the end of the term. If term insurance is not renewable, the company selling the policy can require a medical examination when each period begins. Although a one-year term is the least expensive, one can buy other periods, such as a five-year renewable term. If someone does not want life insurance, the loss of part or all of their investment return to pay mortality and expense charges is a waste.

A man who is paying $100 per year for a $100,000 yearly renewable and convertible term policy would realize that he had received $100 worth of goods and services from the insurance company. He had purchased $100,000 worth of life insurance for the year from the tax-free earnings on the investment within the policy. He bought a needed commodity with pretax dollars rather than with post-tax dollars.

The $100 worth of life insurance was a 10 percent tax-free return on the $1,000 investment in the contract. With convertible term insurance, the policyholder is granted an option. The term policy can be converted into a permanent one. In this way, the permanent policy can be purchased with no questions asked should the insurer find himself or herself in poor health and unable to buy insurance. The going rate, however, will be charged at the time of conversion.

Someone might even be able to buy universal life through their employer. These group plans will contain many of the advantages associated with universal life. They will combine inexpensive insurance protection with a cash accumulation account. The account will earn interest at a market-sensitive rate—that is, the current rate of interest. There will be a guaranteed minimum interest rate.

It will have a flexible death benefit that could be based on the employee's current salary. Money from the cash accumulation account will be added to the death benefit. Group universal life insurance plans offer conversion privileges. Normally, there is a waiver of the premium if a disability occurs. A person also has the option of buying universal life for a spouse or children.

Term "plus" life insurance contains the two basic elements of term insurance, with an investment element added. This element is referred to as "plus."

Term "plus" life insurance includes whole life, variable life, and universal variable life insurance. There are many variations of each.

Some people feel that it is inappropriate to discuss life insurance and investments together. However, it is quite logical to want a return if one has placed additional money with an insurance company. One will earn a return on the extra money that goes into the insurance policy, and there are positive advantages about the return.

The return can be used to pay the mortality and expense charges within the life insurance without the imposition of income taxes. The earnings on one's investment within the contract are not subject to current income taxes. The fact that someone may purchase a consumable commodity—the mortality and expense charges of a life insurance policy—with pretax earnings and currently use that commodity to protect their beneficiaries is unique to life insurance and is often overlooked and certainly underutilized.

Whole Life

Whole life is so named because it lasts for the insured's whole life. The premium stays the same forever. Protection lasts for a lifetime. The critics of whole life state that the policyholder overpays for that protection during the younger years of the insured, which would negate the savings during later years.

Prior to 1976, all life insurance policies issued by companies in the United States had the investment portion invested in the general portfolio of the company. The long-term general portfolio of life insurance companies is comprised primarily of long-term bonds and mortgages. The fixed interest rate long-term bonds and mortgages within the investment portfolio earn the prevailing interest rate at the time they are purchased.

Until 1976, whole life insurance policies that invested in the long-term bonds and mortgages of the general accounts of insurance companies were the only investment type of policy available in the United States. One's policy may have been called a family policy, a life paid up at 65 policy, an endowment policy, a ten- or 20-pay life policy, or even a single-pay life policy.

The names described how long someone paid the fixed premium required by and unique to whole life insurance. Each policy was issued with a fixed face amount and a fixed annual premium. Whole life insurance policies pass investment results through to the policyowner by way of dividends. These dividends are considered to be a return of premium.

The insurance company collects more than is necessary and therefore returns the excess to the policyowner. These dividends are not taxable like dividends received on common stock. They are free of income taxation as long as the total dividends paid do not exceed the total premiums paid into the policy. Prior to the 1980s, this was not likely to occur; today, it is likely to occur in policies that one has owned for a long time.

Traditional whole life is different from term insurance because it offers both protection and cash value. With a whole life policy, the cash value builds slowly. Life insurance companies stress it as a positive for its value as a savings account. Cash value is money that would be paid to a policyholder when the policy is surrendered. This is sometimes called the surrender value of the policy. Simple variations of a whole life policy include universal life and variable life.

With whole life, part of the premium buys the insurance, and part goes toward the cash value. The sales commission hinders the cash buildup during the first few years. It also earns a lower rate of insurance. This interest is tax-deferred and remains tax-free if a person never utilizes the cash value before their death. Insurance products that are whole life may be referred to in other terms.

These include: permanent insurance, ordinary life, straight life, level premium life, and cash-value insurance.

Straight life has fixed payments for the lifetime of the policyholder. Limited payment life is the same as straight life, except the premiums are made for a limited time. For example, it might be spread over 20 or 30 years or by a specified age.

The term "participating" refers to whole life policies that pay dividends that can reduce the actual cost of one's life insurance policy and are also nontaxable. The dividends can be used for the purchase of additional insurance or may be taken in cash.

When deciding on a whole life policy, a person should take into account if the forced savings outweigh the relatively low interest rate they will receive. Traditional whole life pays around 5 percent.

It is this forced savings that might appeal to someone, especially if they are the type of person who cannot put money away any other way. Bear in mind, the price is not cheap. People will be getting less than the market rate on their money and paying a high, up-front commission. In other words, people are overpaying for insurance protection just to force themselves to save. Some people feel that whole life is no investment at all, just a place to park their money because they do not trust themselves with it.

Rather than committing to whole life, one may wish to keep term insurance while considering other financial vehicles that offer forced savings. For example, a person might consider setting up an automatic investment plan to transfer money from their checking account to a mutual fund regularly. Also, before considering whole life, make certain all of the automatic savings plans at one's place of employment are being exhausted, because it might be that the employer will add to one's contributions.

Cash Value

People might question the benefit of any cash value policy when they realize it is not theirs to keep. When they die, it reverts to the insurance company. Some critics of cash-value policies have argued that people are essentially paying their own death benefit. If someone borrows against their policy, they can tap the cash value. It is then subtracted from their death benefit unless it is paid back before their death. It is a good source of ready cash if trouble arises. By law, the death benefit must exceed the cash value. Therefore, if one has held onto the policy for a considerable length of time, the death benefit grows.

The cash value accumulation is slower than one would expect because of the sales commission on whole life. This might be as much as 100 percent of the first year's premium. The commission does taper off to smaller amounts in later years.

Inflation must be considered when discussing cash value. Critics of cash value policies point out that although cash values build, they are worth less every year due to inflation. Actual growth is very slight. One also has to consider inflation in another respect—that is with a term policy one is currently paying. With a whole life policy, a person is spending more in today's dollars to build cash value that will later be worth less because of inflation.

However, proponents of cash value policies could say that a whole life policy lets someone lock into a particular premium now, which they will be paying for later with cheaper dollars. Their premium will look less expensive because of inflation. Whole life can satisfy the need for life insurance at a cost that will remain the same forever.

Stock Versus Mutual Life Insurance Companies

One's whole life policy may have been issued by a stock insurance company as opposed to a mutual insurance company. The difference between the two is that a stock company is owned by its stockholders, and favorable investment returns, favorable expense experience, and lower mortality experience benefit the stockholders.

In a mutual insurance company that is owned by the policyowners, these gains are passed through to the policyowners by way of dividends. The premiums for stock company whole life policies were usually lower than the premiums for an equal amount of insurance with a mutual insurance company. During those early years, stock companies stressed the advantage of the "guaranteed" premium that started out earlier. However, as interest rates rose in the 1980s, the returns within these policies also increased.

Mutual policyowners with whole life policies enjoy those higher returns since they are passed through to them in dividends.

Owners of stock whole life policies have no way to receive these same favorable investment results. As a result, whole life insurance issued by stock insurance companies has now become practically extinct. Most people who have had the opportunity to trade their policies have done so. Healthy people with nonparticipating policies from stock companies may be able to obtain alternative policies that are more economical. They should examine their opportunities to exercise a 1035 tax-free exchange for an alternative life insurance policy.

A whole life insurance policy may be described as a policy that has charges for expenses and mortality, and additional funds invested into the long-term bond and mortgage portfolio of the insurance company. It is a policy that has a fixed premium and fixed face amount.

Variable Life Insurance

Variable life is not just another name for whole life. Variable life combines many features of traditional whole life with a new element. That element is for the insurance purchaser who can live with elements of risk.

Along with the freedom of choosing one's own investments comes the inevitable risk. Variable life insurance can offer higher investment yields than a traditional whole life policy, but one must assume a greater degree of risk. Variable life might be justified if the minimum death benefit guaranteed by the policy satisfies a person's needs, and they can afford to play with the policy in the hopes of achieving a better-than-average return for their family.

In 1977, the first variable life insurance policy was introduced in the United States by the Equitable Life Assurance Society. Essentially, the insurance company created this policy by changing the investment vehicle available within the contract.

The company removed the long-term bond and mortgage account and replaced it with two accounts, a common stock account and a money market account. The policyowner was given the option to use either one or both and to change back and forth between the two. This was the first-generation variable life policy.

This policy, just like its whole life insurance predecessor, had a fixed premium and a fixed face amount. If someone wanted more life insurance, they had to buy another contract. If someone could not pay the premiums when they were due, the policy would lapse, and the value that had accrued in the policy would revert to a fixed life policy under the nonforfeiture provisions available within the contract or default into what is referred to as paid-up extended term insurance.

With extended term insurance, the value in the policy is used up buying term insurance for whatever period of time the cash available will sustain. Relative to the investment performance of whole life from 1977 to 1980, this variable whole life policy performed well. It showed higher cash value increases and better rates of return for the policyowner than comparable whole life contracts, assuming that the policyowner had the assets invested in the common stock account, even though the stock market during those years was not at all strong.

The risk is this: If someone's investments do not perform well, they will be paying a great deal of money for the guaranteed amount of life insurance that remains.

UNIVERSAL LIFE INSURANCE—

THE PRODUCT THAT CHANGED ALL LIFE INSURANCE

Universal life insurance was introduced in the late 1970s and early 1980s. Universal life has been called the ideal policy. It was created to remedy many of the problems associated with whole life. Universal life insurance was a direct response to the demands of the consumer for the high interest rates at that time. In simple terms, one pays a premium, and the insurance company deducts expenses from that premium.

The remainder is then placed in one's investment account within the policy, which is referred to as cash value. As interest is earned, it is added to the cash value. Each month, the portion of the premium allocated to the life insurance coverage is deducted. Insurance companies decided to use relatively short-term investments and to promise policyowners a stipulated rate of interest for a one-year period commencing on the date they purchased their policy.

The interest rates of the early 1980s were high, money markets were popular, and these policies immediately became popular as well.

The insurance company promised policyowners a stipulated rate of return for a year. The policyowners naturally wanted to be able to verify that they actually were receiving the promised rate of return, and so did the regulators. As a result, it was necessary for the insurance company to display to the policy owner, for the first time, the monies in the life insurance contract that were necessary to pay the expenses and the mortality charges required by the contract. The day this happened, all life insurance changed.

For the first time, a life insurance policy was transparent. One could now see interest earnings and mortality costs. Before that time, all that anyone had ever seen involved the end results without an exact breakdown of what was going on inside the policy each month and year. Total disclosure became a reality in life insurance with universal life. The impact of this total disclosure on improving the quality of life insurance products for the consumer has yet to be fully realized by consumers and salespeople.

Universal life brought both total disclosure to life insurance and flexibility to life insurance policies. Whole life dictated to the policyowner a fixed face amount, a fixed annual premium, and a fixed investment vehicle. Variable life had a fixed minimum face amount and fixed premium; however, it gave the policyowner the flexibility of an investment vehicle. Universal life eliminated the fixed premium and fixed face amount but, for the moment, offered no flexibility in the investment vehicle.

One starts off with a renewable term policy, with no cash value and premiums that go up each year. It is combined with an investment account, something similar to a money market fund. The policyowner has the flexibility to adjust either the term policy or the investment account.

The policyowner is also able to mark the amount wanted for insurance and the amount wanted in savings. Universal life provides the policyowner with an annual report in which three columns are presented—the expense column, the mortality column, and the interest column. If the policyowner wants to increase the death benefit, it may be done by increasing the charges in the mortality column and/or the expense column to the extent necessary for the increase.

Reversing that process, if the policyowner wants to reduce the death benefit, the mortality charges are reduced. Thus, universal life offers flexibility of face amount so that the policyowner can use one policy and increase it or decrease it as their life situation dictates.

It also offers the flexibility of premium payments. The policy owner can add to the investment in the policy by increasing premium payments or decrease the current investment by choosing not to pay premiums. The policy is flexible enough to meet changing needs. During a lifetime, a family's needs change at various stages, and one's life insurance coverage should go hand in hand with those needs.

At the very minimum, the policy must have sufficient monies in it to cover the mortality and expense charges.

In some states, universal life is referred to as "flexible-premium adjustable life." This describes many of its benefits. Universal life can be a useful tool to meet changing needs. It can also be useful if one's income fluctuates from year to year. A person can vary their premium if they have a year with a lower income. When someone varies their premium, the death benefit will fluctuate along with it.

Regarding tax advantages, the investment value grows without current taxation. The tax on the interest is deferred while the policy is in force and until the funds are withdrawn. Traditional whole life has that same tax advantage. The sales charges and administrative expenses on these policies might offset some of the advantages, however.

Many insurance companies promote a "kiddie tax." The tax puts children under age 14 in a bad position if they have unearned income of over $1,000. They are taxed at the same time as their parents. Universal life is pushed as a good way for children to build a tax-deferred college fund while obtaining life insurance protection.

Great tax advantages do not make up for a low interest rate. A universal life policy pays no dividends. Instead of dividends, someone earns interest on their cash value. The traditional whole life policy pays a very low rate of interest. The interest on a universal life policy is based on the short-term rates at that particular time and is usually tied to bond market interest rates.

All universal life policies promise a competitive rate. There is always a guaranteed minimum interest rate, which is far below the rate a person expects to get when they purchase a policy of this kind. The guaranteed rate of interest on a universal life policy might only be 4 or 5 percent.

Be sure to determine how the rate of return is calculated and what the correct rate is after the expenses have been deducted. The quoted interest rate might not take all of the policy charges into account.

Universal Variable Life Insurance

The next inevitable step in the evolution of life insurance came in 1985. Policies with universal life that offered flexibility of premium payment and flexibility of face amount, but no flexibility of investment, were combined with variable life that offered flexibility of investment.

In these new universal variable policies, policyowners are given personal control over the life insurance policy's face amount, amount of premium, and types of investment. All three basic features are now controlled by the policyowner. Such control makes these policies very unlike the whole life policies of old. Previously, one could put the policy away and forget about it as long as the premiums were paid on time, and the policyholder had very little control over it.

Policyowners' choices were limited to whether they wanted to borrow on the policy or not, which, at the time, had little or no impact on the investment results of their own policy.

The policyowner could also choose to leave the dividends in the policy or take them out. If someone were not overly thrilled about the investment results of the whole life policy, they could withdraw their capital via policy loans and put it elsewhere. That was the limit of control one had over whole life policies.

Many people borrowed on their policies, especially at the time when interest rates on money market accounts were going up so substantially in the late '70s and early '80s. The insurance policy usually had a fixed interest rate of 5 percent, 6 percent, or 8 percent, guaranteed by contract. During those years, it paid to borrow on one's policy, deduct all the interest while in a high tax bracket, and deposit the borrowed money in a higher interest-bearing account. Policy loans, in most cases, no longer make economic sense when the funds borrowed are to be invested elsewhere to earn a higher return.

Universal variable life insurance gives the policyowner a great deal of control. Policyowner management can make these policies perform extremely well. The policyowner can make decisions not only on face amount but also on levels of funding within the policy (how much the policyowner pays into the contract) and where monies paid into their policies are invested in the policy. This control gives the policyowner flexibility that offers opportunity but also requires responsibility in managing it.

HYBRID POLICIES

There are policies that have been formed to combine features of all four investment policy types. Adjustable life policies are first-generation universal life policies that require highly technical computer tracking systems. This policy requires the policy owner to submit a written request for any changes in the amount being paid on the policy. Upon receiving this request, the company will adjust the policy. For example, paying the lowest premium cost, one's policy would be much like a ten-year term policy. At the highest premium cost, it would be similar to a ten-pay life policy.

The ten-pay life policy is a contract in which the entire investment is invested in the contract within ten years. Afterward, no additional funds can be accepted by the policy.

The written request step of adjustable life allowed the insurance company to go back into someone's policy, reprogram, and reissue their policy on a new schedule. Insurance company officials prefer adjustable policies to universal life because they feel the policyowner will continue to keep paying premiums on the policy if there is encouragement via a premium notice that requires either payment or adjustment.

The adjustable policies do share some flexibility features with those of a universal life policy. Likewise, they often use the guaranteed interest return for one policy year, followed by renewal rates that are based on market and insurance company conditions.

Insurance companies want investments to come into the company each year. Since the adjustable premium policies are less flexible than universal life by changing the billed premium level, adjustable premium policies are more likely to have recurring premiums paid into them than the universal life type of policy. Universal life leaves the payment of premiums entirely up to the policyowner, without requiring any particular action other than sending or not sending the money. For those who need a billed premium to maintain a beneficial investment level in their policy, adjustable life is a good vehicle for this purpose.

The interest-sensitive whole life contract is another hybrid policy. This policy takes the fixed face amount and fixed premium level features of whole life and combines them with the principal used in a universal life policy. This could be the policy for consumers who prefer the annual interest rate guarantee of investment over the long-term bond and mortgages of whole life insurance, yet still seek a fixed face amount and fixed premium policy.

Single-Premium Whole Life Insurance

Single-premium whole life insurance is structured as an interest-sensitive whole life contract, allowing only one premium. Single-premium whole life insurance is a fixed-premium, fixed-face-amount policy with only one premium allowed. The policy is designed to accept at issue the maximum premium allowable, relative to its face amount, under the income tax regulations. That is, the investment in the policy is maximized. Since the investment is maximized, the risk is minimized.

Net amount at risk is defined as the amount that must be paid by the insurance company in the event of the insured's death. This is strictly insurance company money and not a return of the policyowner's investment or account value.

Reducing the amount at risk to a minimum also reduces mortality charges. The underlying investment has as little as possible allocated to mortality and expense charges.

The ability to borrow on the policy without triggering taxation on gains within a single-premium life insurance policy was terminated on policies issued after June 20, 1988. Thereafter, any monies borrowed from single-premium life policies would trigger current taxation to the extent of any gains in the policy. Exceptions to the penalty tax are made in the event of an individual's disability or if there is annuitization of the policy.

One can also maximize premium payments in other types of policies. These policies could include universal life, universal variable life, and single-premium variable life. Universal variable and universal life policies are not single-premium contracts. However, a person can maximize their investment in the policy in a single premium, meaning they pay as much as the law will allow them to pay into that policy at the particular time.

The single-premium policy is an advantageous vehicle for the insured's beneficiaries. It still transfers wealth that has enjoyed tax-free compounding for a substantial time to the beneficiaries without income tax liabilities. All life insurance proceeds payable at death are excluded from income taxation.

Income Tax Benefits of Life Insurance

I. Death Benefits - Income Tax-free

The primary advantage of life insurance is that you contribute a small sum, and, when you die, the whole amount is passed on to your beneficiaries. This is great for beneficiaries as well as society, since these beneficiaries do not become financially dependent upon society. The death benefits of life insurance policies have been exempted from income taxation.

II. Current Earnings and Gains Not Currently Taxed

The second advantage of life insurance is that during the insured's lifetime, and while the policy is in force, all interest earned, dividends earned, and/or capital gains realized on the policy investments are not subject to current income tax. As stated earlier, the taxation is deferred until the gains are taken from the policy by the policyowner. All investment life insurance policies enjoy tax-deferral on this buildup and a possibility of total tax-exemption on investment returns within the contract, which occurs when the proceeds are disbursed as death benefits.

III. Policy Tax Basis Includes Amounts Paid for Life Insurance and Expenses

The third income tax benefit of life insurance containing investment capital is that the amount of money you recover tax-free when you surrender your policy includes all the life insurance costs that the policy has charged during the time the policy has been in force. These costs are paid on a pretax basis even when a policy is surrendered.

IV. Tax-Free Use of Untaxed Earnings and Gains

The fourth income tax benefit of life insurance depends on whether or not you incur taxation as a result of using the monies accumulated within the life insurance policy while it is still in force.

You could use these monies by

- withdrawing them,
- borrowing them from the insurance company, or
- pledging the policy as collateral for a loan.

The income tax benefits of life insurance are provided for a purpose.

They encourage people to buy life insurance policies that provide for family and business security.

College Education, Retirement, Net Worth Build-Up

Accumulating funds for college education(s) and retirement can best be done by using dollar-cost averaging. With dollar-cost averaging, you invest a set amount into an investment at specified intervals of time.

Dollar-cost averaging enables you to invest in volatile investments, such as common stocks, and to avoid failed investments. This strategy may not allow you to generate instant investment returns, but you are likely to grow rich slowly if you practice it consistently over long periods.

The various mutual funds offered by your universal/variable policies are perfectly suited for dollar-cost averaging strategies. Your insurance company will bill you monthly so that you may direct regular payments to the various mutual funds. No income taxes are charged against your accumulated funds. You may make the payments to a common fund, rather than earmarking funds separately.

Trading Life Insurance and Annuity Contracts: The 1035 Tax-Free Exchange

You may find that the life insurance or annuity policy that you have is no longer suitable. If this occurs, don't just surrender that contract. Income taxes and penalties may result from the surrender of a contract that will burden you with unnecessary expenses.

Section 1035 of the income tax code allows you to make tax-free exchanges of a life insurance policy for an annuity contract, or an annuity contract for another annuity contract. You simply trade contracts. You cannot, however, trade an annuity contract into a life insurance policy without taxation.

To effect a 1035 tax-free exchange, you assign your company "A" contract to company "B" and direct company "B," in writing, to put the company "A" contract proceeds into the company "B" life insurance contract or annuity of your preference. If this procedure is followed properly, you should not have to pay income taxes on the transaction. You may, however, have to pay surrender charges to Company A and acquisition charges to Company B. If these are acceptable and the alternative contract is better suited to fulfilling your needs, then proceed.

The advantage of this tax-free exchange is that you will not have to pay any taxes on the gains earned in the original contract at the time of exchange. If there are no gains in the original contract, and there is a loss, surrendering the contract does not allow you to take a deduction for that loss on your income tax return.

Losses as a result of surrendering life insurance or annuity contracts are not deductible. The reason you have a loss in the old contract is that your cost basis, your investment, exceeds the capital accumulated in the contract. The advantage of doing a 1035 tax-free exchange in this case is that you would be rolling that high basis into the new contract.

The higher the basis in your new contract, the more you will be able to take out of that contract in living benefits without taxation. Old policies that have not performed adequately can still be valuable to you in this way. Regardless of the loss or gain in your old contracts, the 1035 tax-free exchange is likely to be to your economic advantage.

The 1035 tax-free exchange is also advantageous if you own a life insurance policy and, at some point in the future, determine that it is no longer needed or appropriate. You can reclaim the money that you have put into your contract (your basis) out of your life insurance policy by making a withdrawal.

Then, with the 1035 exchange of that policy into an annuity contract, you can avoid current taxation on the gain. From that time forward, the investment return within the contract will not be subject to the mortality charges inherent in a life insurance policy, your tax-deferral will continue, and your cost basis in the contract will include all of your previously paid life insurance costs and expenses.

Many old annuity contracts were less flexible and provided lower investment returns to contract holders than do those of today. If you find yourself with a contract of such today, you may opt for a 1035 exchange into an annuity contract that would better suit your present needs and provide better investment returns and flexibility for the future.

Annuities are not strictly payout vehicles demanding equal periodic payments to an annuitant who stands the risk of forfeiting a substantial amount of their investment to an insurance company if they do not live long enough. That situation is easily avoided.

ANNUITIES

An annuity is an investment contract between you and the insurance company. You receive a return on your investment that supplements your contribution. At some point in time, you can choose to "annuitize" your investment to provide income for a specified period in a person's lifetime.

The earnings on your annuity can grow without being diminished by taxes. These earnings are not taxable until you withdraw them, and they are spread out over a number of years. When you begin receiving income from an annuity, only part of the income is taxable because you are receiving both interest and a partial return of your principal.

Another advantage is that you can postpone receipt of income until you are in a lower tax bracket. It can supplement a pension, Social Security, or the income you expect to receive from an Individual Retirement Account (IRA).

To make the best use of the positive tax advantages of an annuity, you must be aware of potential tax problems. Unless you are over age 59 1/2 when you withdraw money from the annuity or cash it in, the IRS imposes a penalty. There is a 10 percent penalty on any earnings withdrawn, along with the tax you owe on the withdrawal. These charges are in addition to any insurance company fees that might be imposed upon the withdrawal.

You should approach the purchase of an annuity with the expectation that you will not draw on it until you're older than age 59 1/2. To fully exploit the tax advantages, you should plan to hold the annuity for many years so that the earnings can grow without current taxation.

No matter what the tax advantages of an annuity are, you must still pay close attention to the rate of return for your investment. You will be choosing between two kinds of annuities—fixed-rate annuities and variable-rate annuities.

Qualified Annuities

Qualified annuities are purchased with funds generated from qualified retirement plans. Contributions to qualified plans generally are not subject to current taxation when they are contributed to the plan. IRAs that qualify for an income tax deduction are qualified plans, as are Simplified Employee Pension Plans (SEPs), tax-sheltered or tax-deferred annuities (TSAs), 401(k) plans, profit-sharing plans, and pension plans.

These qualified plans are unique because, in addition to enjoying the deferral on the earnings within the plan that you enjoy with all annuities, you and your employer may also make capital investments into these plans without having to pay taxes on the amount of investment in the year of contribution. Since you have never paid taxes on the amount contributed to the plan, you do not establish a cost basis. These qualified plans are usually among the best investment opportunities available.

Your employer may encourage you to invest in these plans by offering to match, for example, 50 percent of your contribution. One unique feature of qualified plans is that you are required to begin payouts from these plans, or the annuities that hold the cash in these qualified plans, in the year in which you attain age 73.

For those with qualified plans who elect to make withdrawals from their plans on a joint and last survivor basis, the table for this type of distribution requires an even smaller amount to be distributed.

The Finite-Term Annuity

The finite-term annuity is sometimes called a certificate of annuity because of its resemblance to a certificate of deposit (CD). You can purchase it with a variety of maturity dates. It also lets you choose when to pay taxes. The minimum investment is usually $5,000 or $10,000. The yield is usually slightly less than a bank CD. When the maturity date arrives, you can take your money and pay taxes on the gain. If you do not need the money and don't want to pay the taxes then, then you can roll the money over into a new finite-term annuity.

This annuity investment is an advantage for someone who is over 59 1/2. It is not ideal for someone younger than that, due to the 10 percent early-withdrawal penalty, along with the tax on your gain. There is also a question of safety. It's not quite as safe as a bank CD, although choosing an A+ or A-rated insurance company can come close.

Fixed Annuities

The appeal of annuities is that they have a prospectus of providing an investment that offers a guaranteed annual income after you retire, no matter how long you live. Fixed-rate annuities guarantee a particular interest rate for a specified period of time. After that period of time, only a minimum yield is guaranteed. Today, guaranteed rates for as long as 10 years are becoming increasingly common. Fixed-rate annuities invest primarily in bonds and Ginnie Maes.

Annuities are often called “life insurance in reverse.” While life insurance creates an estate immediately upon the insured’s death, an annuity protects against “living too long.” While many people agree that a long life is a blessing, they also acknowledge that they do not wish to outlast the savings they have accumulated upon retirement. This concern underlies one of the basic attractions of annuities. By assuring continued payments for an unlimited number of years, annuities guarantee that the insured will not deplete their source of income.

The payments one makes for an annuity are referred to as premiums. Premiums, like money placed in a deposit account, earn interest, and these amounts increase in value while the insurance company invests them. The annuity contract also specifies the interest rate that the insurance company will pay on the accumulated fund. A specific interest rate may be guaranteed for one or two years, and sometimes as long as five or ten years. After the guaranteed-rate period expires, the contract may call for the rate to be reviewed at specified intervals, such as quarterly or annually. At that time, the insurance company adjusts the rate in accordance with changes in the general interest rates.

Many insurance companies use the rate paid on Treasury bills as an index for setting the rate paid on annuities. Sometimes, indices such as consumer prices or cost-of-living calculations are used. Most insurance companies also guarantee that the interest rate paid on annuities will never be lower than the particular rate specified in the contract.

When an insurance company receives premiums on a fixed annuity, it invests them along with other funds it holds. (However, not all dollars a contract owner pays are invested since some are used for sales commissions and fees. These charges may vary between companies and contracts. Some companies charge only surrender fees. However, should the insured die before the cash value stated in the contract equals the amount of premiums paid in, most contracts provide for a payment to the beneficiary of at least the amount paid in, regardless of sales charges.)

Immediate Annuities

An immediate annuity provides for payments to commence shortly after the purchase date, according to the preference of monthly, quarterly, semiannual, or annual payouts from the annuity contract.

Deferred Annuities

With a deferred annuity, the contract is arranged for a specific date for annuity payment to begin, also referred to as the maturity date. The time prior to maturity is referred to as the accumulation period. The time following the maturity date during which payments are made to the annuitant (purchaser) is called the liquidation or distribution period. Accordingly, the annuitant will receive payments according to the contract schedule.

Premium Options

Premiums are usually paid for in one of the following methods:

- In this method, the customer pays a single, lump-sum premium when the contract is signed initially. Lump sum premiums can be paid for either immediate or deferred annuities.

- This method pertains to deferred annuities only. The customer pays premiums on a regular set schedule, whether it be annually, semiannually, quarterly, or monthly, until the date on which benefit payments begin.

- This method refers to deferred annuities only and is the flexible premium annuity. This feature permits flexibility in the timing and amount of premium payments. This flexible premium annuity may be preferred by annuitants who want a program in which they can vary the amounts they save each year.

Settlement Options

Settlement options refer to the various ways funds will be distributed from an annuity. Terms are agreed upon by the annuitant and the insurance company when the owner wishes to begin receiving income from the annuity.

Single-Lump Sum

This settlement may be made in a single lump sum. The lump sum includes both the amount the owner paid in premiums and the interest those funds have earned.

Interest-Only Payments

The annuitant may wish to receive interest-only payments until a later date, at which point another settlement option may take effect.

Designated Dollar Amount

The annuitant may elect to have the settlement paid in a specified number or a dollar amount payment over a number of years.

Life Income Option

The life income option is the most common payment associated with annuities. With the life option, the annuitant receives payments until they die. Payments may or may not continue after the annuitant’s death. Three life income options are straight life, period certain, and refund.

Straight Life

A straight life annuity contract provides for guaranteed periodic payments that terminate upon the death of the annuitant. No remaining balance is paid to a beneficiary or to the annuitant’s estate after the annuitant dies.

Period Certain and Refund Options - Some individuals do not want to use the duration of their lives as the factor that determines whether they will profit, break even, or perhaps even lose money on their investments. Therefore, straight life annuities do not interest them. Period certain and refund options guarantee a minimum amount that the insurance company will pay on an annuity.

Both of these options can be regarded as types of death benefits since they provide for payment to be made to designated beneficiaries upon the annuitant's death.

Number of Annuitants

An annuity contract may be written to provide for one or more annuitants. If there is only one annuitant named in the contract, the insurance company agrees to provide that person with income beginning on a specific date and to continue for an agreed-upon period, which is normally the duration of the individual's life.

Some contracts cover more than one person. A popular contract of this type is the joint and survivor annuity. With this arrangement, two people are insured, most commonly the spouses. Beginning on the date in the contract, payments are made to the annuitants. The payments are guaranteed to continue to the surviving spouse upon the other spouse's death. Depending on the contract terms, the continuing payments will either be in the same amount as when both annuitants were alive, or be reduced payments.

Two types of joint and survivor annuities are most commonly used. With a joint and two-thirds survivor option, the surviving spouse receives two-thirds of the income paid to the original annuitant. With a joint and one-half option, the surviving spouse receives half of the income.

Surrender Terms

Another set of annuity contract terms that is important to an investor are the surrender charges. The word surrender describes the termination of an insurance contract, such as an annuity, by the owner. When an individual surrenders a contract, they turn in to the insurance company the documents stating the contract terms. In return, the company gives the owner a sum of money, which is known as the surrender value.

The surrender value is the cash sum that the insurance company agrees to pay the owner in the event the owner surrenders the policy prior to maturity. The surrender value of a policy increases in proportion to the number of premiums paid, but it does not always equal the amount that the contract owner has paid.

The surrender value may be lower than the total premium amount because, under some circumstances, insurance companies will impose surrender charges. Although these surrender charges vary among insurance companies, most annuities stipulate about seven years during which some penalty is imposed.

Surrender charges are one reason that consumers should not attempt to use annuities as short-term, liquid investments in the same way they might deposit accounts. Some annuity contracts do offer loan privileges where the policy owner may borrow against the contract instead of accepting a distribution of cash. However, this may not be helpful, since the loans carry interest charges that vary according to company regulations. Besides this negative, a policy loan is also considered taxable income.

Determining the Mathematical Equation of Fixed Annuities

An annuity is an insurance product providing a life insurance benefit to annuitants. The cost of the benefit is included in the premium paid for the annuity.

Insurance companies use demographic projections as well as complex mathematical calculations to develop and price the annuity products they sell. A company must use projections on average life expectancies when it prices its products, because the number of years people will live directly relates to the amount that the company pays out on its annuities. In turn, statistical projections on the average number of people who will die at different ages influence the amount a policy owner must pay for an annuity.

Mortality Tables

One important mathematical device insurance companies use for pricing annuities is a mortality table. A mortality table is a mathematical tool used to calculate the frequency of deaths that will occur between successive birthdays. The numbers in a mortality table are calculated through the use of probabilities—mathematical equations that express the likelihood of the occurrence of a specific event. Mortality tables are developed by actuaries—insurance specialists who are experts in mathematics. Actuaries calculate risks, premiums, reserves, and other mathematical factors for insurance companies.

The numbers in a mortality table allow an insurance company to project its likely future obligations to annuitants. Similarly, the company uses the mortality table to project how many dollars will be released to it by annuitants who die. This information, together with statistics the company gathers on the interest it can earn on its holdings plus the production of operating costs, is then used to calculate the premiums to be charged for annuities as well as its other products.

Investor Considerations

The promise of a guaranteed lifetime income during retirement may be attractive to many investors. However, a guaranteed income is only one factor that should be considered when considering annuities. Among the other issues that should be examined carefully are risk, liquidity, earnings, and taxes.

Risk

Annuities are relatively safe investments. While they are not covered by federal deposit insurance, the principal and interest an individual invests in a fixed annuity contract are provided by the rigid state and federal regulations that govern insurance companies' operations. However, these regulations do not protect an investor from all potential problems.

If the insurance company that sold an annuity to an individual experiences severe business problems and becomes insolvent, other insurance companies doing business in the same state will be required to help meet that company's remaining obligations. However, the annuitant may face extra paperwork and delays in attempting to obtain funds.

Additionally, it is a good idea to research the soundness of the insurance company before purchasing an annuity from it. One way to do this is to use Best's Insurance Reports, a publication that reports on and rates the financial strength of life insurance companies. Your local public library may normally have these in its reference section.

Liquidity

Annuities are relatively liquid investments because they provide ways for individuals to surrender their contracts and withdraw their funds during the accumulation period. They are not completely liquid, however, since investors may not receive the full amount that they have paid in premiums if they decide to withdraw from their annuities. The amount that an individual would lose depends on the surrender fees and penalties assessed by the insurance company. These charges are described in the annuity contract.

Earnings

Interest earnings on annuities have attracted many current investors. Rates in the last few years have been competitive, generally paying somewhat more than typical CDs. Guarantee periods vary with different insurance companies. Some will pay an initial rate for one or two years, followed by subsequent annual guarantees. Others will peg their rates to formulas based on Treasury bills or consumer price indexes.

A desirable feature that a careful buyer will seek in an annuity is the bailout provision. With this provision, the contract owner may bail out without paying any surrender charge if the rate falls below a certain designated percentage of the original rate, even if the initial guarantee period has expired.

For example, assume the initial guaranteed rate is 8 percent for one year. The contract promises a 1 1/2 percent bailout provision. The contract also says that a surrender charge is made upon a premature withdrawal anytime within seven years from the purchase date.

After the initial one-year period of the contract, the company announces that the next year's interest rate will be 6 1/2 percent. Since this rate dropped 1 1/2 percent from the initial rate, the customer is entitled to avoid any surrender charges if the contract is cashed in.

Income Tax

One of the main appeals of deferred annuities is the income tax advantages that are offered to investors. Investors pay no taxes on the earnings during the accumulation period; taxes are deferred until the liquidation period. Once payouts to the annuitant begin, only a portion of each payment is taxed as income. The remaining portion, which is not subject to income taxes, is considered a return of the money that the investor paid into the annuity during the accumulation period.

The portion of an annuitant's income that is subject to taxes is determined through a calculation required by the U.S. Department of the Treasury. This complex calculation is based on the projection of the amount the annuitant will receive in annuity income if they live to life expectancy.

This total income is referred to as the expected return. Once an expected return is determined, the next step is to calculate the percentage of the amount that was invested in the contract. Once the percentage is calculated, it is used each year to determine how much of the annual annuity income should be considered return of capital and how much should be regarded as taxable income.

The Tax Reform Act of 1986 added some income tax penalties to annuities. One important addition was a 10 percent penalty applying to lump sum withdrawals from annuities before age 59 1/2. This penalty applies whether the amount is taken as a loan or an outright withdrawal. (There is an exemption to this 10 percent penalty if the amount of withdrawals before age 59 1/2 is part of a series of approximately equal periodic payments over a lifetime. Also, exempt are such payments in the event of death or disability.)

While annuities retained their general tax deferral benefits under the new law, an important exception was made in the case of business-owned annuities. If a business entity, such as a corporation, partnership, or trust, owns an annuity on an employee's life, any interest earnings or annual gains in the contract are subject to current income taxes.

Annuities that are part of qualified plans, such as pensions and similar employee benefit programs, are exempt from the ruling. Immediate annuities are also exempt. (In addition to employer pension plans, the exclusion of taxable earnings on annuities applies to IRAs and 403 (b) tax-sheltered annuities sponsored by certain nonprofit corporate employers.)

Variable Annuities

Characteristics of Variable Annuities

To better understand the structure of the variable annuity, compare it to the fixed annuity described earlier. Like the fixed annuity, the variable annuity is a contract between an individual and a life insurance company. With both types, the owner contributes premiums that, along with their earnings, are accumulated within the policy contract. At an agreed-upon time, the insurance company begins making payments to the annuitant. Payments are made over the individual's lifetime or for some other stipulated period.

With variable annuities, your rate of return depends on your investment skills. You will be able to choose from a variety of mutual funds. The basic difference between fixed annuities and variable annuities is the way in which accumulated funds are invested and the resulting payout.

With fixed annuities, the accumulated funds are combined with the insurance company's general investments. These investments help form the basis for the guaranteed cash values of life insurance and conventional annuity contracts. In general, insurance companies invest funds for their fixed products in long-term bonds and other non-speculative issues.

In comparison, the premium payments made on a variable annuity are not combined with the insurance company's general investments. They are placed in stocks, government securities, and other types of fluctuating investments. These investments have better growth potential than those that underlie investments, but also are subject to a greater degree of risk.

The investments make up a portfolio that is managed in much the same way as a typical mutual fund. When you're ready to receive payment, you can choose a payout option that suits you and that does not depend on your skill in choosing investments.

For many years, marketers of annuity products as well as savings institutions emphasized the advantages of conservative and secure investments. During the 1930s, when the U.S. economy was experiencing only moderate inflation rates, many people purchased annuities for retirement in the belief that they insured a comfortable, guaranteed income for life. A successful insurance company advertisement of the late 1930s enthusiastically proclaimed, "Retire for life on 300 dollars a month!"

Then, rising inflation rates began to affect the average person's standard of living. Beginning in the 1960s, people became aware that they had to plan for more retirement dollars just to keep pace with anticipated increases in living costs. Savers sought financial instruments that could more readily keep up with inflation. Individuals of even average means were turning to the stock market for an increasing portion of their investments. Like savings institutions, insurance companies looked for ways to improve their traditional products. In an attempt to combine traditional annuity guarantees with the growth potential of a securities investment, the variable annuity was developed.

Types of Variable Annuities

Variable annuities generally are divided into two basic types. The difference between them lies in who has control over investing the money deposited into the annuity. With the first type, the company-managed variable annuity, the insurance company determines how the annuity funds are invested. With the second type, which could be referred to as a self-directed variable annuity, the annuity owner has substantial control over the investment of funds.

Company-Managed Variable Annuity

The original variable annuities, which were introduced in the 1950s, were company-managed types. In this type of annuity, premiums paid by contract owners are pooled and placed in a separate account designated by the insurance company. This method serves to distinguish these investments from the company's other invested funds. (One advantage of a variable annuity is that if the insurance company runs into financial problems, the funds in the separate account are beyond the reach of the company's creditors.

This is also true for the portfolios in self-directed plans.) The account is organized like a mutual fund in that it is made up of various investments—usually stocks, bonds, and government securities. The insurance companies' investment managers buy and sell these investments on a continuing basis.

Like mutual fund managers, the insurance company tries to invest the money wisely and profitably so that it will generate a competitive return for its investors. In addition, the insurance company must meet both state and federal regulations regarding investment practices for these products. (Variable annuities are subject to regulation by the Securities and Exchange Commission, Internal Revenue Service, and state regulatory bodies.)

One of the better-known company-managed annuities is the College Retirement and Equities Fund, or CREF. Designed by the Teachers Annuity and Insurance Association, it was the first variable annuity, appearing on the market in 1952. Because of CREF's relatively long history, it has been the subject of many detailed studies.

Self-Directed Variable Annuity

With the self-directed annuity, the contract owner can choose from several investments, each with different objectives. The selection of investments may be made during both the accumulation and distribution periods. In effect, the contract owner may construct a personal investment portfolio within the annuity. The owner selects investments based on their investment objectives in much the same way that a mutual fund investor does.

Choosing an Annuity Investment Portfolio

The annuity application form lists the selection of investments that the insurance company offers. For an example of a hypothetical self-directed variable annuity, consider that there are five selections available. These include four mutual funds with differing objectives, plus a fixed account. The fixed account offers guaranteed safety of the principal and specifies a fixed interest rate. (Interest rates on the fixed account may be guaranteed for periods ranging from one calendar quarter to one or two years or even longer.) Customers choose from among these options according to their investment objectives.

On the annuity application, the customer indicates, usually in percentage units, how each premium is to be allocated among the selected accounts. Most contracts allow an unlimited number of percentage combinations. The applicant can even allocate the entire premium to a single investment choice.

Changing the Investment Mix

One distinguishing characteristic of self-directed annuities is the owner's ability to change the composition of the annuity portfolio.

Three major factors that affect how individuals invest their assets are their investment objectives and philosophies, their financial standing, and economic conditions. Since each of these factors may change over time, it is advantageous to the investor to be able to change the way in which their money is invested.

As an individual progresses through life, their investment philosophy and objectives often change. Many people who previously might have been inclined to take investment risks may become more cautious as they grow older. For the owner of a variable annuity, a change to more conservative investments may mean moving money from stock funds to funds composed of government securities or even a fixed fund. The typical self-directed variable annuity offers the contract owner the opportunity to redirect the investment of funds as their investment objectives change.

Changes in one's financial standing may also alter an individual's willingness to accept risks. For example, some individuals may invest in more aggressive and risky funds only after they have accumulated what they consider an adequate nest egg. Similarly, some individuals move their variable annuity funds into conservative options if they experience losses in their other investments.

Economic conditions and forecasts may also lead an individual to take advantage of a variable annuity's flexibility. When stock prices are expected to fall, some individuals direct their money out of stock funds and into other types of funds. When yields on other investments are falling, investors often move their money into bond funds because these are generally considered good investments during such a period. Thus, variable annuities allow the investor to react in the face of changing market conditions.

Computation of Annuity Accumulations and Payment/Payout Options

Annuities are quite different from the life insurance products we've looked at previously. You can structure an annuity so that the payout will continue for a specified length of time. This period can extend beyond your lifetime if you choose that option.

Therefore, payments from an annuity do not always end upon your death. Furthermore, there are life insurance policies that pay benefits prior to death if a catastrophic event occurs.

Straight-Life or Lifetime-Only Annuity.

The terms of this agreement stipulate that you receive a monthly income for life, which the insurance company estimates. Another payout option is receiving income for the rest of your life, with a guarantee. This is called an annuity with life-and-period certain. You are guaranteed that payments will continue for at least the designated period, whether that period is 10,15, or 20 years. In this way, you are sure to get your money's worth out of the annuity, even though it might not be you who collects. Your beneficiary would collect for the full guaranteed period.

You can also choose an income for a fixed period. You select the length of time you'll receive the annuity payments. The length of time you select will determine how much you get per month. Living longer won't help you with this option. The payments stop after the specified period ends. You can also choose an option of telling the insurance company how much you need, and it calculates the payout accordingly.

Other options are installment-refund annuities and cash-refund annuities. They return your original annuity investment to your beneficiary if you don't outlive the amount you put in.

Owners of variable annuities receive regular statements on the value of their investment accounts. Like CD owners and other investment holders, annuity owners want to know the current values of their holdings.

Computing the value at any given time of a variable annuity contract can be complex. With a variable annuity, one is dealing with fluctuating stock market investments. The process, therefore, is more complicated than calculating the value of a CD, which has a guaranteed interest rate over a specified period.

You do not have to choose any of the payout options during the accumulation phase of the annuity. It is best to wait until you're ready for payments to begin. At that time, you will know what your financial needs are. You are also able to choose a payment schedule that takes full advantage of the tax laws in effect at that time.

Accumulation Units

During the years in which premiums are paid into the contract, the annuity owner acquires accumulation units. Accumulation units have a designated initial price at the time of the annuity purchase but fluctuate in value thereafter. In the case of company-managed products, the changing values will correspond to the performance of the pool of investments. This is similar to the way mutual fund values are expressed. With a mutual fund share, each accumulation unit of a variable annuity has a designated value on a given day. In the case of self-directed annuities, the values of the fund or combination of funds the policy owner has chosen are totaled. The value of each accumulation unit is then calculated from this total.

Under both company-managed and self-directed plans, each premium payment purchases a certain number of accumulation units. The number of units varies according to the unit's current market value. The number of units continues to increase, as additional purchases are made, although each unit's value will vary over the life of the contract according to its worth in the marketplace. This, too, is similar to how mutual fund share values are calculated.

Annuity Units

In order for the insurance company to begin paying out income from the annuity, accumulation units are converted into annuity units. An annuity unit is a measure of value that an insurance company uses when it calculates the amount of income to be paid to an annuitant. At retirement, the annuitant is credited with a designated number of annuity units.

The exact number of annuity units to be credited depends on four basic factors. One is the annuitant's age. The insurance company calculates from its mortality tables all charges in order to provide a designated amount of lifetime income at a specified age.

The second factor is the number of guaranteed payments. If the annuitant chooses a period-certain life income option, the extra charge for that benefit will be reflected in the calculation of the annuity unit.

The third factor is the interest rate that the insurance company projects. If the company predicts a fairly high interest rate, the annuity unit will have a greater value than it would with a lower rate. Interest rates are typically projected annually to determine the projected investment return.

Finally, there are administrative expenses to be incorporated into the unit cost calculation.

Fluctuating Value of Annuity Units

The calculated number of annuity units remains constant over the payment period. The annuitant has the option of choosing a fixed or a variable payment, or, as is often the case, a combination of both. With the variable payment, the annuity unit's value may fluctuate just as it does during the accumulation period. The value will continue to vary according to the performance of the underlying investment portfolio and the general administrative costs that the company incurs. The amount of periodic income will also fluctuate.

There are two important reasons for the continued fluctuation in variable annuities after the retirement income period begins.

The first is that the portfolio's value constantly changes to reflect current market conditions.

The second is that the investments funding the annuity contract also change continually, just as they do during the accumulation period. The various stocks, bonds, and other financial instruments that make up the portfolio continue to supervise this process. In a self-directed plan, the contract owner may frequently change the contents of the portfolio.

Performance History of the Variable Annuity

The initial objective of the variable annuity concept was to design a financial instrument that would combine the guaranteed features of annuities and the growth possibilities of equities. One popular theory was that the cost of living and common stock prices tend to move in the same direction over the long run. During the 1950s and 1960s, there did seem to be a definite correlation between rising stock prices and the cost of living. However, a comparison of the consumer price index and Standard and Poor's index of 500 stocks from 1970 to 1987 shows wide fluctuation even during periods of accelerated inflation.

CREF Annuity

To see the relationship between cost-of-living changes and annuity unit values, consider the CREF annuity. Participants in the CREF annuity had ample reason to be disturbed when, beginning in 1973, the CREF annuity unit value dropped almost 40 percent in three years. Consumer prices were skyrocketing.

Individuals who had already started drawing their annuity benefits saw their payments decrease while the cost of living increased. (CREF reevaluates its annuity value once each year and fixes its monthly payment amount for the following 12-month period. Many other variable annuity issuers pay a varying amount each month.) The downturn affected both retirees and those who were still investing for the future. The value of the accumulation units in annuity contracts dropped over 50 percent during that time.

Therefore, even those who were still accumulating funds were disappointed to learn that fund values did not appear to conform favorably to current economic conditions.

However, when computed over a longer time, the CREF annuity unit value tended to increase along with the cost of living. From 1967 until 1987, the payout rate increased by 385 percent during a period when the cost of living had risen 245.7 percent.

While this data represents a close correlation between the rise in inflation and annuity payouts, other periods did not show the same results. For example, between 1970 and 1983, the consumer price index increased each year. However, the value of the CREF annuity unit increased only during seven of those years. In total, while the consumer price index rose about 157 percent, the value of the CREF annuity unit increased only about 47 percent.

Some financial authorities have explained this phenomenon by proposing the existence of a definite relationship between inflation and stock prices. They point out that when prices rise rapidly, there is a corresponding increase in interest rates. When interest rates rise sharply, the stock market reacts by moving in the opposite direction. Therefore, when the cost of living takes a sudden jump, it seems that the value of the variable annuity unit tends to fall.

In fairness, it must be noted that other variable annuity companies had similar experiences at the time. Proponents of the variable annuity, however, assert that they have never viewed their product as a temporary hedge against sudden inflation. To them, the variable annuity is based on the assumption of a long-term correlation between inflation and investment returns. Based on this principle, a variable annuity would be a favorable investment because it would allow investors to enjoy a rise in income as the economy's productivity increases.

The variable annuity has achieved nationwide acceptance. The latest available figures indicate that, at the end of 1988, there were well over five million variable annuities in force with a value of more than $50 billion. (Life Insurance Fact Book - Washington, D.C.: America Council of Life Insurance, 1988.)

Investor Considerations in Purchasing Variable Annuities

The variable annuity, with its combination of traditional guarantees and investment flexibility, offers great promise as a financial planning tool. It has the potential to be more responsive to economic trends than the conventional savings account or even the traditional fixed annuity. However, the savings customers who have basically considered only fixed investments should be aware of the special concerns connected with the purchase of a variable annuity.

Risk

There are two important points to keep in mind regarding the risks of variable annuities. One concerns the insurance company that issues the annuity, and the second concerns the investment's fluctuating nature. Regarding the first point, it is essential to note that, while both fixed and variable annuities are marketed by savings institutions, neither product is covered by federal insuring agencies. The investment is backed by the guarantee made by the insurance company that sells the annuity contract.

Although the insurance industry's record of financial stability has been very good, the annuity purchaser should investigate the company that issues the contract. While the savings institution marketing the annuity will have investigated the insurance company, the counselor must explain to the customer that government insurance does not apply to annuity products. In previous cases of insurance company failure, other insurance carriers have assumed the failed company's financial obligations. However, this process has entailed some delays. Furthermore, although the principal was safeguarded, the interest earnings promised in the original contract were not always credited to the investor.

The second area of risk is the fluctuating nature of the variable annuity. Investors should recognize that whenever they place money in variable annuities, the dollar value of their investments is subject to both upward and downward changes. An investor should assess their risk tolerance when selecting a variable annuity and composing the annuity portfolio.

Particular caution is needed during the retirement period when the contract owner may be contemplating changing investment strategies. Many owners like a more conservative investment position at the time when they were making deposits and accumulating funds. While it is possible to increase income payments by making the right investment choices, it is also possible to make the wrong decisions. Unlike during the accumulation period, when there is sufficient time to make up for a temporary loss, once retirement begins, it is difficult to recoup any losses resulting from investment mistakes.

Choosing an Annuity Type

Determining which type of variable annuity is suitable for an investor depends mainly on two factors.

- One is the potential purchaser's investment sophistication. The other is the extent to which the person wishes to become involved in investment decisions.

  The first consideration applies to the inexperienced investor with limited knowledge of the stock market. In this case, a company-managed variable annuity is probably the better choice, since the insurance company will make all the investment choices and manage the portfolio.

- The second factor concerns whether the contract owner wishes to continually monitor changing economic conditions and be responsible for changing the direction of investments in the annuity portfolio. With the self-directed type of variable annuity, the investor decides on the mix of investments in the portfolio. It is the contract owner's responsibility to periodically review these investments to see whether their performances are still in tune with their investment objectives and adjust the portfolio accordingly. The self-directed plan is probably more suited to an investor who is accustomed to making these types of decisions.

Insurance Company Charges

The investor should also be aware of the various charges that the insurance company's fund managers impose. Each annuity contract has its own schedule of fees and other charges, and the investor should carefully assess these before making a purchase.

One charge that is commonly imposed is a surrender charge. This is similar to the surrender charge for fixed annuities.

Typically, the surrender charge limits the amount of money that may be withdrawn during the early years of the contract. Some policies have a declining charge. For example, the charge might be 6 percent for the policy's total value in the first year and decrease by a percentage point each year thereafter. Thus, no surrender charge would be imposed on withdrawals made after the sixth year.

For funds invested in company-managed accounts, companies usually impose management charges. Fairly typical contract charges are $25 per year for administration plus an investment management fee of 1 percent or more of the variable account's total value. Funds held in a fixed account usually escape the investment management fees. The insurance company typically justifies these fees by providing for a guaranteed death benefit and covering the administrative expenses involved in providing a life income.

Income Tax Considerations

The income benefits of fixed annuities also accrue to the owners of variable annuities. Under current law, income taxes are deferred until the contract owner withdraws funds from the annuity.

These tax laws give the variable annuity owner some definite tax advantages. For example, when a person invests in mutual funds, they must pay income tax on the yearly dividends and capital gains, even if the shareholder actually receives no payments during the year. Under the annuity "umbrella," on the other hand, the owner may invest in mutual funds and not be subject to income tax until any gain is actually paid out.

This income tax benefit is one of the major advantages of using a variable annuity to accumulate retirement funds. With a prudent investment policy that takes advantage of stock market conditions, an individual can create a nest egg of retirement income. Income taxes will not affect this personal fund during the accumulation period; it is only when money is withdrawn that taxes become due. Further, when a person withdraws lifetime income from an annuity during retirement, they will probably be in a lower tax bracket than during the accumulation years.

Evaluating an Annuity

As with many other types of insurance policies, you need to shop around for the annuity that's right for you. You should compare the company's A.M. Best rating, interest rates, and any fees that the company might charge.

As a general rule, you should not be purchasing an annuity unless you plan to keep it for many years. Even after you choose an annuity, you might need to shop around again when you go from the accumulation phase to the payout phase. You'll usually do better by converting your present annuity than buying a new one.

If, however, another company can do more with your money, you can switch to another annuity without causing yourself a tax problem. Essentially, you are using your funds at the new company to buy an immediate annuity. When you're looking at your options, shop around to make sure that another company can't offer you a better payout with the same amount of money. Keep in mind, as well, that one insurance company might not offer the best monthly payout for every option. Each company's financial data and loss experience will be different. For example, one company may not believe you will live as long as another company thinks you will, and it may offer a better monthly payment.

Term Life Insurance "Plus"

The first generic form of life insurance is term insurance, in which you pay just enough to cover the mortality and expense charges. All other forms of life insurance are policies that require mortality and expense charges, plus an extra amount for investment purposes. Part, all, or more than your total investment return will be used to cover mortality and expense charges as required by the net amount at risk (amount of insurance company money that would be paid to the beneficiary in the event of the insured's death). Term "plus" contains the two basic elements of term insurance — mortality and expense charges — and adds to them an investment element, the "plus." Term "plus" life insurance includes whole life, variable life, universal life, and universal variable life.

The additional money put into an insurance company in order to earn a return is unique in that it can be used to pay the mortality and expense charges that are within the life insurance contract without the imposition of income taxes. The earnings on your investment within the contract are not subject to current income taxes. The fact that you may purchase a consumable commodity with pretax earnings and concurrently use that commodity to protect your beneficiaries is unique to life insurance and is frequently overlooked and underutilized.

Whole Life

Prior to 1976, all life insurance policies issued by companies in the United States had the investment portion invested in the general portfolio of the company. The long-term general portfolio of life insurance companies is comprised primarily of long-term bonds and mortgages.

The fixed interest rate long-term bonds and mortgages within this investment portfolio earn the prevailing interest rate at the time they are purchased. It was this type of fixed interest portfolio that was exposed to the incredible, rapid increases in interest rates that brought the prime rate up to 21 1/2 percent by December of 1980. In that environment, a mortgage note or a long-term bond with a 5 percent, 6 percent, 7 percent, or 8 percent interest rate decreased in value as alternative interest rates went up.

It was at this point that the Federal Trade Commission chose to examine insurance company investments. Until 1976, whole life insurance policies that invested in the long-term bonds and mortgages of the general accounts of insurance companies were the only investment type of policy available in the United States. Your policy may have been called a family policy, a life paid up at 65 policy, an endowment policy, a ten—or twenty-pay year life policy, or even a single-pay life policy. The names describe how long you paid the fixed premium required by, and unique to, whole life insurance.

Each policy was issued with a fixed face amount and a fixed annual premium. Whole life insurance policies pass investment results through to the policyowner by way of dividends. These dividends are considered to be a return of premium. The insurance company collects more than is necessary and therefore returns the excess to the policyowner.

These dividends are not taxable like dividends received on common stock. They are free of income taxation as long as the total dividends paid do not exceed the total premiums paid into the policy. Prior to the 1980s, this was not likely to occur; today, it is likely to occur in policies that you have owned for a long time.

Insurance Company, Product, and Agent Selection Criteria to be used in selecting insurance companies are financial strength, longevity, and integrity. You will want to deal only with companies rated A or A+. Insurance companies are primarily regulated by the individual states. The states vary in the quality and quantity of their regulation.

If the insurance company you have chosen is licensed to do business within your resident state, you have that one level of protection.

A second source of public information is the A.M. Best Company of Oldwick, N. J., the oldest insurance industry rating service. This company provides information regarding an insurance company's financial condition, a synopsis of its history, information on its management, operating commitments, and the states in which it may write business. A.M. Best Company also grants its own ratings to companies, designed to reflect strength in four areas, including: underwriting, expense control, reserve adequacy, and investments. In most cases, you would be wise to place your trust in companies rated A or A+ by Best's.

Standard and Poor's has a service that rates a very modest number of companies on their "claims paying ability." Major employers trying to find a source for their guaranteed interest contracts for their retirement plans would use this service to evaluate the financial strength of competing insurance companies. Standard and Poor's Corporation is located at 25 Broadway, N.Y., NY 10004. These reports are generally not available to the public unless the insurance company that purchased the report chooses to make it available to you. You will need to ask for it.

Operational Analysis

Through an analysis of operating results, Standard & Poor's determines a company's ability to capitalize on its strategy and company strengths. Operating results are analyzed independently of the company's operating leverage. Pretax return on revenue is an important determinant of return on assets.

Key ratios used in the evaluation of operational performance include:

1. Underwriting performance.
2. Premium growth rates.
3. Loss ratios.
4. Expense ratios.
5. Combined ratios.
6. Loss reserve adequacy.
7. Investment Activities.
8. Invested asset allocation strategy.
9. Invested asset credit quality.
10. Portfolio diversification.
11. Liquidity.
12. Return (current yield and total return).
13. Interest rate risk management.

Through the analysis of each of these broad areas and the effective tax rates, the identification of how a given level of return on assets is generated. Standard & Poor's then looks at the trend in return on assets over time and relative to the industry as a whole. The objective of this phase of the analysis is to have a clear understanding of the company's ongoing profitability.

Quantitative Rating Methodology

The process Standard & Poor's uses to statistically categorize insurers is a series of minimum criteria screens combined with added filters. The weakest insurers will fail at multiple characteristics, all of which are equally important. Subsequent screens assess the remaining insurers until those with the strongest financial profile remain. The same methods are applied to rating reinsurers and primary insurers, except for added factors for reinsurers. While the fundamental characteristics of financial health are similar for all insurers, "failure" of a reinsurer is a somewhat different concept than for a primary writer.

In the past ten years, hundreds of primary insurers have been taken over by state regulators because of financial concerns, but relatively few reinsurance companies have met this fate. Far from immune to financial problems, reinsurers that have encountered trouble have been more apt to voluntarily cease accepting new business, be rescued by a parent company, or merge with another reinsurer.

Within the secure range, there are no restrictions on ratings that can be achieved by an insurer based purely on its size, except that insurers who do not meet a minimum size criteria may not be rated. However, size does play a supporting role in the determination of an insurer's quantitative claims-paying ability rating.

Social Security Benefits

During your working years, your wages are posted to your Social Security record, and you receive Social Security earnings credits based on those wages. These credits are used later to determine your eligibility for Social Security retirement benefits or disability, or survivor benefits if you should become disabled or die.

You receive a maximum benefit of four credits per year from your work earnings. The credits you earn will remain on your Social Security record even if you change jobs or have a period of no earnings.

The number of credits you must have to be eligible for Social Security benefits depends on your age and the type of benefit. Everybody born in 1929 or later needs 40 credits to be eligible for retirement benefits. People born before 1929 need fewer credits.

The Social Security credits you earn also count toward eligibility for Medicare when you reach 65. You may be eligible for Medicare at an earlier age if you are entitled to disability benefits for 24 months or more. Your dependents or survivors also may be eligible for Medicare at 65 or if they are disabled.

People who need kidney dialysis or a kidney transplant for permanent kidney failure may be eligible for Medicare at any age.

If your pension is from work where you also paid Social Security taxes, it will not affect your Social Security benefit. Pensions from work that are not covered by Social Security, such as Federal civil service or some State or local government systems, however, will probably reduce the amount of your Social Security benefit.

Social Security Checks

Social Security benefits are paid on the third day of the month.

If the third falls on a weekend or a Monday holiday, benefits will be paid on the previous Friday. If your check is not delivered on its due date, allow three more workdays before reporting the missing check to Social Security.

A Government check must be cashed within 12 months after the date of the check, or it will be void.

Paying Taxes on Benefits

A relatively small number of people who get Social Security have to pay taxes on their benefits. You will be affected only if you have substantial income in addition to your …

Social Security benefits.

If you file a federal tax return as an "individual," you might have to pay taxes on your Social Security if your combined income exceeds $25,000.

If you file a joint return, you might have to pay taxes on your benefits if your combined income exceeds $32,000. (On the 1040 tax return, your "combined income" is the sum of your adjusted gross income plus nontaxable interest plus one-half of your Social Security benefits.)

If you are a member of a couple but file a separate return, you probably will pay taxes on your benefits.

No one pays taxes on more than half of their benefits. Some pay taxes on a smaller amount of their benefits according to a formula developed by the Internal Revenue Service.

After the end of each year, you will receive a Social Security Benefit Statement (Form SSA-1099) in the mail showing the amount of benefits you received. You can use this statement when you are completing your federal income tax return to find out if any of your benefits are subject to tax.

Only wages and net self-employment income count toward the Social Security earnings limit. Income from savings, investments, or insurance will not affect your benefits. For the earnings limit, income counts when it is earned, not when it is paid. If you have income that you earned in one year, but the payment was deferred to a following year, it should not be counted as earnings for the year you receive it. Some examples of deferred income include accumulated sick or vacation pay, bonuses, stock options, and other deferred compensation.

The earnings limit is the amount you can earn and still receive all your Social Security checks. This amount increases each year. You will be notified of the new amount each January.

Reporting One's Earnings

If you earn more than the earnings limit and you receive some benefits from Social Security, you must complete an annual report of earnings. In this report, you provide your exact earnings for the previous year and an estimate for the current year.

In the year you turn 70, Social Security only counts your earnings for the months before you reach 70. You do not have to fill out a report if you are 70 or older all year. You can report your earnings by phone or by completing an Annual Report of Earnings form. This form is available by calling your Social Security office.

If Social Security knows you are working and you receive some benefits during the year, Social Security will send the form to you automatically. You must submit an annual report of earnings by April 15 of the following year. If you do not receive a report form in the mail by the end of February, you should call Social Security to have one sent to you.

There is a substantial penalty for not filing an annual report of earnings on time. You can be penalized for up to one full month's benefits for a first violation in addition to being required to repay any overpayment. Filing a federal income tax return does not take the place of filing an annual report with Social Security.

Supplemental Security Income (SSI)

If you have limited income and resources, Supplemental Security Income (SSI) may be able to help. SSI is a federal program administered by the Social Security Administration, but financed from general revenues, not from Social Security taxes.

It pays monthly checks to people who are blind, disabled, or 65 or older. If you get SSI, you may get other benefits too, such as Medicaid, food stamps, and other social services.

Some income and some resources are not counted in determining eligibility for SSI. Your house and your car, for example, are usually not counted in the resource limit. Qualified retirement contributions can be made with various investment options in developing a pension plan within your insurance policy.

These qualified plans are generally not subject to current taxation when they are contributed to the plan. Be sure to realize that change is inevitable, and you must be flexible when considering life insurance and annuity contracts to enhance your and your family's financial security.

If you would like to retire someday at 100 percent of your standard of living, you will have to take advantage of Social Security, your employer's qualified retirement plans, and save 20 percent of your gross income each and every year. There is no better way to begin this personal accumulation pattern than by participating at the maximum level possible in the employer-provided plan that allows you to invest with pretax dollars.

You can continue to work and still get all of your Social Security benefits as long as your earnings are under certain limits. These limits increase each year as average wages increase. You can work and earn up to the limit and still get all your Social Security checks. If your earnings go over this limit, some or all of your benefits will be withheld.

SECTION III: FINANCIAL PLANNING & BUDGETING

Finance, Economics, and Accounting

Finance is closely aligned with accounting and economics. Accounting may be considered a necessary input to the function of finance. Two broad areas of economics affect the development of finance. Macroeconomics includes the aggregate economic and institutional environment in which a business must operate.

Microeconomics covers an assessment of the preferred or optimal operating strategy for a given business.

The Role of Finance in a Business

The significance of finance in any particular business depends largely on the size of the business. In a smaller business, the financial function is ordinarily integrated with that of accounting. In larger business organizations, there is typically a separate financial department that is usually headed by a vice president of finance.

The financial department is concerned with a wide variety of items, such as credit, obtaining financing, acquiring, and disposing of fixed assets, the distribution of earnings to shareholders, financial planning, and budgeting. Most of the responsibility for the day-to-day activities of business financing falls upon a financial manager.

Responsibilities of a Financial Manager

The responsibilities and functions of a business financial manager are threefold and include the following:

Management of a business's financial structure—This function involves a determination of the most suitable combination of short- and long-term financing, which has a direct impact upon the liquidity and profitability of a business. Another element of this function is ascertaining when long- or short-term financing is required.

Management of the asset structure of a business—A financial manager must determine both the types of assets to be included on a business's balance sheet and the appropriate mix of such assets. He must keep each type of asset at an optimal level and know when to replace fixed assets that have become obsolete.

Financial analysis and planning—This duty requires changing financial information and data into a form that can be readily used to assess a business's financial position and the requirements for increased production, plan for future financial needs, and decide what additional financial funds are necessary.

Introduction to Financial Planning and Budgeting

Financial planning and budgeting have become an integral part of the successful operation and management of any business, regardless of its size and form of ownership. Thus, a financial plan and budget are just as critical to a sole proprietorship as they are to a multi-billion-dollar international public company.

Financial planning is rooted in a trend toward long-range planning that began in the decade of the '50s and became prevalent in the '60s. With increased business use of computers, financial planning and budgeting have evolved into a sophisticated methodology characterized by buzzwords, such as "spreadsheets," "trade experience curves," "pro formas," "cash-flow projections," "tracking," and "strategic business reports."

General Electric was one of the first major corporations to structure its business along the lines of strategic financial planning when it introduced the concept of a "strategic business unit" in the late '60s. Texas Instruments initiated a connection between financial planning and the measured discipline of management of programs.

The "experience curve," which involves a correlation of production costs and a growth-share matrix with the relative market share of a business, was developed by the Boston Consulting Group. It is probably a safe assumption that most contemporary businesses employ some form of financial planning and budgeting in order to develop a successful method of competition in the marketplace, which hopefully will lead to a profitable enterprise.

Financial business planning and budgeting, whether long- or short-term in nature, are in essence a framework or blueprint for operating managers of a business to implement goals and objectives in a manner consistent with the overall plans and strategies of a business. Whether financial plans and budgets cover a monthly, quarterly, annual, or five-year period, they are in effect a plan showing how management intends to acquire and use resources for the business for a definitive period.

Basic Financial Planning Concepts

The Importance of Long-Range Planning

Long-range business planning is essential to the survival, growth, and profitability of any business enterprise. Long-term objectives must be formulated and communicated to department managers and employees so that the company's goals and objectives can be successfully implemented.

Effective planning for the future depends on management having a cogent view of the company's present strengths and weaknesses in relevant areas, such as products, productivity, capital assets, return on investment, markets, profits, competition, morale, industrial trends, financing requirements, and governmental regulation.

Long-term financial planning is essential to minimize or avoid the detrimental impact upon a business resulting from unforeseen vagaries and uncertainties in the marketplace and the surrounding political, social, economic, and international environment.

One who engages in long-range financial planning and budgeting can by no means be expected to function as either a prophet or a wizard. Long-range business planning is a complex procedure accompanied by a substantial degree of uncertainty, and all the more so as the period covered by the planning and budgeting increases.

Financial Planning to Avoid Crises

The worst thing a business can do is assume the future will take care of itself. Failure to anticipate, analyze and plan for several factors that affect the operation, profitability and perhaps the very survival of an enterprise, such as relative risks, performance within a given industry, technological innovations, labor supply, governmental laws and regulations, availability of materials, sources of capital for expansion, degree of competition and to plan for product diversification and a new pool of customers in the event of a crisis can spell disaster for a business.

Tools of Financial Planning

Budgets—Perhaps the central feature of any short- or long-term business financial plan is the budget. A budget is a quantitative economic plan covering a specific period. An understanding of several words is critical to the definition of a budget, including:

- **Quantitative—**a budget must quantify tangibles. The goodwill and reputation of a business are not susceptible to such measurement.
- **Economic—**terminology employed in a budget must be economic in nature. Adjectives that are broad, such as "excellent services" or "durable products," do not qualify.
- **Plan—**a budget is not a synonym for a forecast. It is merely a statement of the intentions and goals of management with respect to the use of business funds and anticipated income and expenses relative thereto for a specified period of time.
- Time—budgets generally are long- or short-term in nature and cover a specific period of time, such as five years, one year, a quarter, a month, or a week. There is no such thing as a true open-ended budget.

Budgets function as a reality check on the visibility of a business's future objectives and goals. Budgets can also be used to assist a business in attaining its goals by implementing each separate element.

Because of inter-departmental dependency, budgets are useful in coordinating different business activities and informing various divisions about what other departments are accomplishing. Budgets are useful for executives to communicate business goals to subordinates. Goals are set within a business function as motivating factors for employees and can be employed to set standards for evaluating performance levels.

Pro forma financial statements—Pro forma or prospective financial statements consist primarily of a pro forma balance sheet and a pro forma statement of income. The statement of income is, in essence, a cash-flow projection for a business and is perhaps the most critical financial statement for controlling and managing a business.

The importance of ratio analyses, profit and loss statements, balance sheets, and strategic analyses statements cannot be minimized as tools of financial planning, but all are dwarfed in comparison to the cash-flow statement if cash flow for a given business is negative.

A pro forma statement of income or budget is designed to give guidance to a business in answering two questions that are critical to profitability: when and how much. For example, management of a business involves timing—how much is a bill and when will it get paid, when can cash be expected to result from sales, or when can a business enterprise expect the proceeds of a loan, and at what rate and frequency must the loan be repaid.

Long-range cash-flow projections help in segregating capital needs, whereas short-term statements of income are useful in the day-to-day operations and management of a business and for presentations to lending institutions or investors in the event of a need to borrow funds or raise equity.

A capital budget is also known as a pro forma balance sheet. It contains projected liabilities and assets of a business for a specified period of time.

Sources and uses of fund statements—A review of income statements, statements of net earnings and balance sheets may not reveal answers to several crucial questions, such as the amount of cash generated by operations, why dividends were insignificant when profits were up and the amount of money spent on capital equipment and the source of such funds.

Answers to such questions can be found in the statement of changes in financial position, which is generally required when a balance sheet and income statement are used. A statement of changes in financial position is referred to as a "funds statement" and reflects the flow of funds in and out of a business.

The major objectives of fund statements are:

- To describe the changes in the financial position of a business for a given period.
- To summarize substantial investing and financing activities of a business.
- To disclose funds from operations.

Funds relate to cash and working capital, and thus, fund statements can be used to track every transaction that increases or decreases either cash or working capital. The issuance of debt or equity securities for cash or in exchange for property would be included. When funds are classified as working capital, the significant sources include funds from sales of non-recurrent assets, operations, issuance of stock, and borrowings. Such funds are typically used for investment in capital equipment, acquisition of treasury stock, redemption of outstanding debt, payment of dividends, and financing of operations.

Short-Term vs. Long-Term Planning

Budgeting and financial planning for a business can be either short- or long-term in nature. Short-term budgets and financial plans may be referred to as operating plans or budgets, and they typically address the daily, weekly, or monthly use of resources and the creation of utilities, services, and products. An operating budget usually covers a period of one year and includes such items as labor, general and administrative overhead, sales, cash flow, and materials. Operating budgets can be divided into three classes:

Working capital budget—this type of budget normally relates to the working capital requirements of a specific project.

Profit budget—this is a budget that sets forth the resources to be used and the products or services to be sold. Prices are fixed so as to anticipate costs and related income.

Cash budget—a budget that plans for accounts receivable and accounts payable.

Long-term financial planning and budgeting, sometimes referred to as strategic or capital planning, covers an extended period, usually five or more years, and may include the following items:

- Capital holdings.
- Products.
- Return on investments.
- Markets.
- Profits.
- Capital investments.
- Employee-employer relationships.

The following factors should be taken into consideration when preparing and implementing long-term financial plans and budgets:

- Economic changes.
- Growth of the industry.
- Changes in technology.
- Sales potential.
- Capacity.
- Growth of the business.
- Capital expansion.
- Equipment replacement.
- General and administrative overhead.
- Research and development.
- Financing needs.
- Dividends.
- Governmental laws and regulations.

Long-range planning and budgeting should contain a statement by management of its goals relating to the size and scope of business operations, customer service and development, employer relations, services, and products to be offered and sold, product diversification, product quality, plans for capital investment and purchase of equipment and research and development.

FINANCIAL FORECASTING

Financial forecasting may involve a statement by management of a business concerning anticipated future net income, revenues, and earnings per share. Such statements may be shown in dollar amounts or dollar ranges.

Under the rules and regulations of the Securities and Exchange Commission, a public company may publish forecasting materials under limited conditions. Such forecasts must be revised whenever the originals are no longer founded on any reasonable basis.

If projected figures are not achieved within the given period, the company providing such forecasts is protected from liability under the federal securities laws. Financial forecasts cannot be selected or inflated if the assumptions do not support such projections. Financial forecasting is a sensitive matter because of the direct impact it can have on a business's legal liability, the price of its stock, its competitive positioning in the marketplace, ongoing negotiations with labor unions, and potential governmental regulatory intervention.

Ratio Forecasting

Ratio forecasting involves anticipating or projecting the future success of a business by analyzing various indices of a company's past and present levels of performance. There are immeasurable indices of performance that can be analyzed as a basis for future achievement and economic success.

Such factors can be reduced to ratios. A ratio is simply the result of one number divided by another. The result stands apart from the component numbers and is only significant as a measure of performance as far as it relates to other comparable ratios. Financial ratios, like any other economic statistics, indicators, or measures, may need professional interpretation to be meaningful.

The following are some of the more frequently used forecast ratios:

- **Profit and investment**—measure the ratio of profit to investment.
- **Return on capital**—involves a return on capital expressed as a percentage of investment. This is perhaps one of the most basic of all ratios used for financial planning and analysis.

Balance sheet ratio

A company's economic health depends in part on the existence of healthy economic proportions, and such indexes are often expressed as balance sheet ratios that include:

a. **Solvency ratios**—measure the ratios of current assets to current liabilities, liquid assets to current liabilities, and cash to equity.
b. **Equity ratios**—used as a measure of to what degree a company is financed by its shareholders and may include the ratio of the amount of equity to either total capital employed, fixed assets or equity, and long-term debt.
c. **Operating ratios**—these indices are used to measure the performance of a business in terms of capital employed and sales.
d. **Sales ratios** include the ratio of sales to total capital employed, equity, current assets, working capital, stock, or debt.
e. **Return on equity**—may be measured in terms of a ratio showing net profit to equity, sales, or working capital.

Safety margin ratios—investors in a company may elect to evaluate or measure the margin of safety of their investments by assessing the ratio of the net profit of the business to either interest paid on debentures or other indebtedness or to the amount of gross dividends paid within a given period.

Quick ratio—provides an analysis of liquidity by subtracting inventory from current assets and dividing the results by current liabilities.

Debt to total capitalization—this is total long-term debt divided by stockholders' equity plus long-term debt.

Debt-to-equity—allows an analyst to ascertain whether a company depends more on debt or equity for financing. The total long-term debt is divided by shareholders' equity.

Leverage ratio—used by companies in evaluating whether to go back into the equity market for additional financing and the degree to which existing shareholders will have their equity interests diluted. The leverage ratio is ascertained by dividing the total assets of a business by the total stockholders' equity.

Inventory turnover—this ratio is important in evaluating the operational aspects of a company and is calculated by dividing the total sales of a business by the total inventory. If the ratio is too low, it is likely that too much capital of a business is tied up in inventory.

Average collection period—important to an analysis of cash flow, the average collection period can be determined by dividing the total accounts receivable by daily sales volumes.

Price-earnings ratio—this index is used to indicate whether the relative price of a stock is high or low. It is calculated by dividing the price per share of a stock by the earnings per share.

Price to cash flow—another ratio used to determine the value of a stock relative to other stocks in companies in the same or a similar industry. The ratio is determined by dividing the stock price per share by the cash flow per share.

Price to book value—this factor is used to determine what a shareholder would realize upon the liquidation of a business and is determined by dividing the price per share by the book value per share.

Dividend yield—to determine the percentage of dividend paid on a stock, the annual dividend rate is divided by the stock price.

Dividend payout—to determine how much of its earnings a business pays out to its shareholders in dividends, it is necessary to divide the annual dividend rate by the earnings per share.

Trend Analysis

Trend analysis is used when financial information about a specific business is set forth for at least three or more years. The beginning or earliest period serves as the base period. In the base year, each item of a financial statement is established at 100.

In later years, the same separate item is established as a percentage of value in the base year by dividing a dollar amount in a later year by the amount in the base year. That way, the relationship can be demonstrated between the rate of growth or decline of two or more items in the financial statement.

Trends in net income can be measured against sales trends, for example, or general and administrative overhead can be compared to product costs.

The overall goal is to analyze various trends that are related and predict whether such trends might continue.

BUDGETING

One of the most important aspects of business financial planning is budgeting, which involves the integration of financial and non-financial planning to attain the goals and objectives of any business organization. Several fundamentals are critical to effective budgeting, including:

1. **Support of top management**—the significance of the budget must be communicated to all levels of management.

2. **Participation of subordinates**—middle management and support staff should be given ample opportunity to participate in setting goals and objectives to be implemented through a budget.

3. **Responsibility accounting—**those budgetary costs that an employee has control over should be addressed in their performance review.

4. **Communication**—all those who participate in the preparation of a budget or who are affected by its operations should receive periodic reports on the status of the budget and should be able to provide input for any revisions.

5. **Flexibility**—assumptions underlying a budget may become invalid or stale over a period of time, and thus, those involved in budget preparation must maintain a certain level of flexibility.

Accounting information is an integral part of budget preparation. Line items or separate elements of a budget must be consistent with the account of a business. Such accounts must facilitate preparing not only the budget but also company financial statements and various other annual and periodic financial reports. There are various types of budgets used in business financial planning.

Two of the more important ones include the capital budget and the master budget.

- The master budget consists of an operating budget and a financial budget.
- The operating budget is the projected or pro forma income statement, and the financial budget is the projected or pro forma balance sheet.

The financial information included in pro forma balance sheets depends to a great extent upon the data underlying the pro forma income statement. Operating budgets—An operating budget or a pro forma income statement involves expected projections of profit and loss.

Past operating data is used to project profit and loss for an extended period of time, usually for three, five, or 10 years. Pro forma income statements are always based upon assumptions and actual results, and may vary considerably due to unforeseen or enforceable circumstances.

Such income statements take into account the following budgetary aspects:

1. **Sales budgets**—several factors must be considered during the process of developing a sales budget, including:
   a. Detailed examination of historical sales information.
   b. Analysis of general economic activity.
   c. Prospects and trends for the industry.
   d. Position of the business within the industry.
   e. Strengths and weaknesses of competitors.
   f. Sales quotas and expected sales prices.
   g. Management's goals regarding profits.
   h. Specific types of costs to be included under selling expenses.

A sales budget is generally prepared in units and subsequently converted to dollars.

2. **Production budgets**—the primary goal of a production budget is to harmonize the time and amount of the production of goods or services and their sale. Excessive accumulation of inventory and raw materials must be avoided. Determined by a business's inventory policy and the sales budget, a production budget is developed initially in units.

   A production budget may be subdivided into budgets covering the expenses of overhead, labor, and materials.

3. **Budgeted gross income**—every business receives revenues or payments for the sale of goods or the provision of services, and at the same time incurs expenses to others in connection with engaging in business operations to generate revenues. Budgeted gross income is the amount of income a business expects to generate within the budgetary period, without regard to any deductions for expenses from the sale of goods or services. Frequently, production and sales budgets may have to be adjusted in either direction depending on the amount of budgeted gross income. Production and sales expenses, along with corporate operating expenses, cannot exceed gross income for a significant period without the business becoming insolvent.

4. **Corporate operating budgets**—many contemporary businesses have followed the trend set in the '70s to decentralize operations. At the same time, the administration of general corporate affairs has become centralized. The administrative affairs of a business may be conducted at its corporate headquarters, while sales and manufacturing may occur at branch or remote facilities. As a result, it may be necessary to have a corporate operating budget in addition to a production and sales budget.

5. Anticipated income might include such items as receipt of interest and dividend income, and funds from the sale of business assets, the sale of debt or equity securities, or funds attributable to any other investments. Budget expenses might include costs relating to general and administrative overhead, such as rent, taxes, utilities, mortgage payments, property insurance, employees' salaries and benefits, expenses of selling debt or equity securities, and the costs of acquiring property or a new line of business.

Cash Budgets

A cash budget or forecast allows a business to provide for cash requirements on a short-term basis. Typically, a cash budget covers a one-year period, and such a period is divided into intervals. Businesses whose cash flow is seasonal may break cash budgets into monthly intervals. Projections of both cash receipts and cash disbursements are required in order to support operational budgets.

Daily cash projections and reports prepared by corporate officers are facilitated by cash budgets. A cash budget for a given period starts with beginning cash and equivalent balances, increased by all cash receipts and decreased by all capital and operational expenses that have actually been dispersed. Then, additional cash sources are projected, as are cash disbursements for the projected period. Cash budgets are useful for lenders to estimate how well any corporate or business debt can be serviced.

Capital Budgets

Capital budgets are a crucial tool in long-range business financial planning, especially with respect to the analysis, planning, and acquisition of fixed assets. Such budgets plan the liquidity of a business for extended periods, usually measured in years. Some capital budgets may be prepared in the form of a continuous budget.

One of the problems inherent in the preparation of a capital budget is just how far ahead to plan. The horizon of foreseeability should define the period. Thus, it may be difficult to do any long-range budgetary planning for businesses that are seasonal in nature or which operate in an unstable social, political, or economic environment.

Several important factors must be considered in preparing a capital budget, including:

- Capital financial needs.
- Credit and stock policies.
- Governmental regulation.
- Competition.
- Future general and administrative overhead costs.
- The effects of automation on the workforce.
- Equipment replacement.
- Additional equipment.
- Growth capacity.
- Technological changes.
- Economic changes.
- Industrial growth.

In essence, the capital budget is a projected or pro forma balance sheet that projects all liabilities and assets, except cash, which will exist at the end of a sub-period. The cash figure to be shown is obtained by subtracting all liabilities from the total assets. The point around which all capital budgets rotate is "net cash flow," which is one of the projected elements of profitability.

FUNDS FLOW ANALYSIS AS A FINANCIAL PLANNING TECHNIQUE

Since business involves a series of decisions to utilize assets for an economic return, which includes a proper blend of financing, the investment of resources, and the operation of a business, management must have a method of expressing and evaluating the movement of resources in monetary terms.

Based upon profits and losses and periodic accounting statements, a concept known as a funds flow statement has been developed. A funds flow statement affords a business financial analyst a comparative method of isolating deviations in financial conditions and the resultant impact upon business operations.

A framework for the use of funds can then be structured. Generally accepted accounting methods must be understood by a business financial analyst since accounting statements form the basis for efficient funds flow analysis.

Funds flow statements are of major significance to those whose financial information about a company helps determine whether or not to loan money or make an investment in the equity of a business.

For a long time, investment and financial information relating to a business were set forth in a financial statement covering the flow of funds known as a "statement of changes in accounting position." Its utility lies in depicting both the inflow and outflow for a specified period of financial resources or funds.

Such funds were typically known as working capital or cash. Those businesses that issued financial statements were required to include a statement of changes in accounting position based upon cash or working capital, provided the financial statements purported to present both the financial position of the company in the form of a balance sheet and a statement of income and retained earnings which set forth the company's results of operations.

During the decade of the '60s, both the Accounting Principles Board and the American Institute of Certified Public Accountants issued formal recommendations that a funds flow financial statement should become an integral part of the financial statements of any reporting business.

In 1970, the Securities and Exchange Commission adopted regulations requiring financial statements of all public companies to contain a funds flow statement.

Because of divergent practices that developed concerning the preparation of funds flow statements, the Accounting Principles Board issued a formal opinion, commonly known as Opinion No. 19, in 1971. Opinion No. 19, entitled "Reporting Changes In Financial Positions," required a funds flow statement to be included in financial statements and suggested that such statements should be designated as a "statement of changes in financial position."

In the final analysis, Opinion No. 19 created multiple interpretive problems through the use of ambiguous terminology, by failing to recognize varying reporting formats used by different businesses, and by encouraging the reporting of changes in the amount of assets and liabilities instead of the flow of funds.

Opinion No. 19 came under intensive criticism because of its limited degree of usefulness, by permitting the use of the working capital notion of funds rather than the concept of cash flow in evaluating and predicting a company's economic strengths and weaknesses.

In 1987, the Financial Accounting Standards Board issued its "Statement of Financial Accountings Standard No. 95" ("Statement No. 95"), which succeeded Opinion No. 19. Statement No. 95 requires the inclusion in financial statements of a statement of cash flow rather than a statement of changes in financial position whenever a company presents financial statements that purport to represent that both results of operations and financial position are included within a business's financial statement.

The primary purpose of a statement of funds flow, now typically known as a statement of cash flows, is to present information about a business's receipts and payments of cash for a specified period, and to present data about a company's financing and investing activities.

The Funds Flow Statement

What is it? —A funds flow statement or a statement of cash flows is a financial statement that includes a summary for a specified period of a business's cash inflows and cash outflows, as such relates to the financing, investing, and operating activities of a business.

Just like one frame in a motion picture cannot tell the complete story, a statement of cash flows cannot be examined in isolation, but must be viewed in connection with a company's balance sheet, income statement, and statement of retained earnings. A statement of cash flows is complementary to the financial statement by revealing the quantity of cash that flows from operational activities and to the balance sheet by revealing transactions of cash flow that result in variations or changes in stockholders' equity, liabilities, and assets.

How is the information gathered? — The preparation of a funds flow statement is a procedure that essentially involves four steps, including the following:

- ✓ Changes in cash and cash equivalent accounts must be determined for the specific reporting period.
- ✓ All accounts must be analyzed to see if cash payments or receipts were involved in any changes.
- ✓ Total net cash flow must equal the net increase or decrease in cash.
- ✓ All inflows and outflows of cash must be classified as related to either operating, investing, or financing activities.

Specific requirements for reporting financial information in a cash flows statement are set forth in Statement No. 95.

Inflows and outflows of cash are broken into three specific categories that include those relating to:

- ✓ Operating activities.
- ✓ Investing activities.
- ✓ Financing activities.

The manner of presentation of a funds flow statement must show a reconciliation of beginning and ending balances of both cash and cash equivalents. Cash equivalents include highly liquid short-term investments of a nature such that they can be easily liquidated into cash.

Such investments must have a maturity of three months or less. U. S. Treasury bills, commercial paper, and money market funds typically qualify as cash equivalents. In further discussions, the term "cash" will include "cash equivalents."

Operating activities are usually a company's most significant revenue-generating activities. Statement No. 95 provides two approaches for reporting cash flows resulting from operating activities—the direct approach and the indirect approach. The direct approach is the method preferred by the Financial Accounting Standards Board.

Under the direct approach, at a minimum, the following significant sources of operating cash inflows and cash outflows must be included:

- ✓ Cash received from customers, lessees, and licensees.
- ✓ Other operating receipts.
- ✓ Cash from interest payments.
- ✓ Cash from dividends.
- ✓ Operating receipts.
- ✓ Cash receipts.
- ✓ Cash paid to employees and suppliers.
- ✓ Income taxes paid.
- ✓ Interest paid.
- ✓ Cash paid for the purchase of inventory.
- ✓ Cash paid for utilities and rent.
- ✓ All other operating expenses.

Under the indirect method, operating accounts and cash flows are shown by adjusting net income for such items as revenues, expenses, gains, and losses that, while they do not directly affect cash, do appear on the income statement. Additionally, net income is adjusted for operating cash inflows/outflows that do not appear on the income statement. Interest and income taxes paid must be disclosed elsewhere throughout the financial statements, in footnote form. Items such as depreciation expenses and gains on the sale or transfer of equipment are noncash items that do not affect cash flow.

Cash flow from investing activities includes events that relate only indirectly to the pivotal ongoing operations of a business, including the offer and sale of goods or services. In deciding which investment activities to report, cash flows from the following business activities would be included:

- ✓ The sale of a segment or a unit of a business.
- ✓ The sale of property, plant, or equipment of a business.
- ✓ The proceeds from the repayment of loans to another entity.
- ✓ The sale of investments in either debt or equity securities.

Cash payments that would be included are those made in connection with the following business activities:

- ✓ The purchase of property, plant, or equipment.
- ✓ The purchase of certain instruments, such as debt or equity securities.
- ✓ Any loans made by a business to another entity.

Business financing activities include transactions that yield resources or those in which payments are made to persons or entities that provide debt or equity financing to a business enterprise, such as creditors and stockholders. While such transactions relate to financing and investment activities, the payment of interest and the receipt of interest and dividend payments are reported as income from operations.

Company Sources of Funds

Although business funds are typically thought of as cash, in reality, there are other methods of funding business operations, such as credit and the exchange of business assets for other property.

A funds flow statement, an important source for identifying business funds, contains information and provides answers to questions that may not be included in either a balance sheet, an income statement, or a statement of retained earnings, such as how much funds were spent on plants and equipment, and the origin of such funds.

Business funds include both cash and working capital. If funds under consideration are cash funds, every event or transaction that increases or decreases cash must be included in a funds flow statement. Such a statement consists of two sections. One may be headed as "cash or working capital provided or generated," and the other may be entitled "cash or working capital applied."

Uses of Funds

Funds defined as working capital are generated internally by selling nonrecourse assets and by the sale of services, goods, products, merchandise, or inventory. The external sources of business funds include borrowing from financial institutions and the receipt of funds from the sale of debt and equity instruments, such as company debentures, notes, commercial paper, and common or preferred stock.

Significant uses of funds, whether generated internally or externally, include investment in non-recurrent assets, such as plants and equipment, redemption of company debt, acquisition of treasury stock, payment of dividends, and under limited conditions, meeting ongoing expenses of operations such as the purchase of raw materials and inventory, and the payment of both rent and utilities, and general and overhead administrative costs and expenses.

Funds provided by operations differ from net income due to the inclusion of certain items in net income that do not affect working capital funds, such as depreciation expenses.

Funds Flow Analysis

Information set forth in a statement of funds flow, especially when used in conjunction with other financial statements and schedules, is of value to a business financial analyst in assessing the potential future cash flow of a company. Specifically, items that can be evaluated include the ability of a business to pay its debts, to pay dividends, and to satisfy external financial demands.

A statement of funds flow can assist an analyst in understanding the difference between income flows and cash flows and in evaluating the nature and extent of a business's investing, operating, and financing activities.

Funds flow analysis provides investors, creditors, and other business financial analysts with a three-dimensional view of a company's economic status. By examining each of the three levels of business activity, various issues and questions relating to such activities can be addressed.

A statement of funds flow includes information related to cash provided by or used by a business's operating activities, and could provide significant information about why a business making substantial profits has a chronic deficiency of cash. Conversely, the issue of how a business generating large inflows of cash can continue to operate at a loss may also be resolved.

With respect to cash provided by financing activities, a prospective lender or investor might be interested in determining if financing for the reported period was obtained through the issuance of equity and debt securities, and if so, the amount of such financing that was obtained.

Also of possible interest might be whether the business used cash to retire any long-term debt or equity securities.

A prospective lender might look to cash provided by or used in connection with investing activities to ascertain if a borrower is making capital expenditures to modify, replace or expand obsolete or worn-out equipment or plants, if income-producing assets or other long-term investments were acquired or if any cash was realized from the sale of non-recurring assets.

There are many other indices of financial strengths and weaknesses of a business that can be evaluated by a business financial analyst, including the following:

- **Quality of earnings**—an important factor in assessing the relative strengths and weaknesses of a business is the quality of earnings, which is assessed by measuring how closely cash flow from operating activities correlates to earnings. If the correlation is high, so also is the quality of earnings.

- **Solvency**—if a statement of cash flows indicates that a business is having substantial trouble paying its debts when due, insolvency may be a short-term possibility.

- **Liquidity**—a business is said to have a high degree of liquidity if it can produce sufficient amounts of cash for any given business purpose.

- **Financial flexibility**—this aspect of a business relates to its ability to adapt to a period of adversity or downturn in either the economy or the specific business in which a business is engaged by obtaining financing, converting non-operating assets to cash, or by modifying its operations to generate near-term cash inflow.

- **Comparison with other businesses—**a statement of cash flows complements the income statement by avoiding a number of arbitrary allocations and estimates required in an income statement, such as depreciation expenses. Also, since generally accepted accounting practices allow more variation in the preparation of income statements than for a statement of cash flows, the latter would be a better tool for comparing the cash flows of different companies.

- **Extension of credit—**the current reporting period may reflect cash collected from sales in a previous period in which customers were extended credit. Collections on accounts receivable must be added to revenues reported on an income statement to show the full picture regarding cash collected from customers in a given period. Likewise, increases in accounts payable represent additional purchases on credit, which, when added to the cost of goods sold as reported on income statements, will show an analyst the total amounts sold to suppliers of merchandise for the given period.

FINANCIAL PLANNING MODELS

Inherent in business financial planning and budgeting is a significant degree of uncertainty and risk. In response, financial planners have developed techniques that center around the concepts of risk, measure the risk of a project, define the relationship between time and risk, and provide approaches to adjusting budgets and financial planning for risk.

Fundamental Concepts of Risk

Risk—A number of external factors can determine the relative success or failure of a business. Such factors are those over which business managers have little or no control and include such determinants as technology, governmental regulations, the general state of the economy, war, political turmoil and unrest, competition, labor forces, and specific market conditions.

When financial plans and budgets are drawn up for a business, the variations in expected returns are shown to reflect risk and uncertainty. Certain cash flows are based upon a financial planner's knowledge of the probabilities of specified cash flows occurring. The decision-maker can estimate or predict probability distributions. Such a distribution is objective when it is founded on historical information. Lacking such historical data, only a subjective probability distribution can be made.

Sensitivity-based analysis of risk—Sensitive analysis of risk, one of the more forward and easier methods of assessing the risk of a business project, involves utilizing a number of possible outcomes. A variety of cash flow or fund flow estimates are used to assess the divergence of possible outcomes.

Estimations of outcomes of a project or of cash flow range from the worst or the most pessimistic to the most optimistic or the best results, with less extreme indexes in between, such as the expected or most likely outcome. Thus, an index of risk can be provided in terms of a range. Of course, the greater the range, the greater the risk inherent in a project.

Payoff models or matrices can be prepared for various projects using the initial investment and cash-flow estimates to calculate a range of risks.

Assessing risk through assignment of probabilities—The percentage chance of an outcome is the probability of its occurrence. Thus, if a specific outcome of 60 percent has been predicted, the likelihood of the occurrence happening is six out of ten chances. Assignments of probability or likelihood determine the expected value of cash flow. The expected value is simply the likely return of a project that is repeated a number of times. It does not matter whether probabilities are measured subjectively or objectively—the calculation is basically the same.

Project Risk Measurement

The evaluation of different proposed projects for a business is enhanced by being able to measure the uncertainties inherent in budgeting for capital expenditures. There are basically two methods of assessing the variability of the returns on projects. One employs statistical measurements to hopefully arrive at a solid index of project variability. The other requires the development of probability distributions for visual assessment. Probability distributions are outcomes and associated possibilities that can be charted on an outcome-possibility axis. The simplest is the bar chart, which shows a small number of probability coordinates. When all of the likely or possible cash-flow outcomes are known along with the relevant probabilities, a continuous probability distribution can be mapped or plotted.

The development of continuous probability distribution charts is a relatively complex matter, requiring the gathering of information on a great number of historical occurrences of an event. With such information in hand, a business financial planner can develop a frequency distribution by showing just how many times a result has been obtained over a given period of time.

Time and Risk

Time is an essential ingredient in evaluating the risks involved in business financial planning. A more short-term financial plan, such as an operating budget, is not as susceptible to the effect of unknown parameters as is a budget for capital or long-term expenditures. The projection of cash-flow outcome on a longer term, such as beyond one to five years, can be affected adversely by such factors as the general economy, the political environment, and the state of the particular economy at hand.

Risk/time element—Generally, the longer the time, the greater the risk when it comes to forecasting cash inflow and cash outflow for a given business project. Distributions of probability of funds flow become more divergent with the length of time because it simply is not possible to engage in probabilistic forecasting over a longer period of time. Forecast values thus become riskier as the underlying time increases.

Portfolio risk—Often, when capital budgeting is undertaken, one must look at the number of projects involved. Existing, as well as proposed, projects in a portfolio must be analyzed with a view of selecting projects that diversify or minimize the overall risk. The sum of the risks of the projects involved in a portfolio should be less than the risk of individual projects if risk is to be minimized. Models or charts can be prepared showing the results of using the same statistical measures for each project. Positive correlation between different projects occurs when the numbers move together. Negative correlation is indicated by the results moving in opposite directions. If the correlation does not differ by a coefficient of plus or minus one, the two projects are quite likely to go a long way in diversifying risk.

Capital Asset Pricing Model

The capital asset pricing model was developed to allow potential investors to measure the effect of an investment in a security on the overall portfolio risk and return.

It is also useful in providing guidance in understanding the nature of trade-offs involving risk and return that should form part of the long-term budgeting process. The capital asset pricing model is founded on a few basic assumptions related to market efficiency and preferences of investors. Studies have validated the reliability of such assumptions, which include:

- **Investor preferences**—many investors prefer to acquire equity securities that provide the greatest or lowest return for a comparable level of risk. Generally, the lower risk is preferred.

- **Efficient markets**—the secondary market for securities is assumed to be rather efficient, providing all investors with equal access to accurate information about the issuer of securities. The common holding period for an equity security is presumed to be one year. The investors hold an insignificant amount of stock, so they cannot impact the volume or pricing of the stock in the market. No transactional costs or payment of taxes are assumed.

The capital asset pricing model is the fundamental matrix that measures the significant non-diversifiable risk and return for any asset. The first value that must be determined is the beta coefficient, which for an asset is its historic returns concerning returns for the market. Market returns can be measured by an index that contains the performance of the entire market of such assets.

For example, if the assets in question are securities, a stock index such as the Standard & Poor's 500 Stock Composite Index could be utilized. The market beta is always stated in terms of one, and any other beta is measured with such an index or value. Most betas take on a positive value, and negative ones are rare in the marketplace.

When a capital asset pricing model is depicted in graph form, it is referred to as the security market line. The results are always depicted in a straight line. Beta or b, as a function of risk, is plotted on the horizontal or x-axis, and returns are set forth on the vertical or y-axis.

The capital asset pricing model can be used to make many kinds of internal financial decisions, including capital and operating budgets. Whatever its use, the capital asset picking model is predicated upon numerical information used to estimate expected returns. However, the underlying betas do not necessarily reflect the future diversity of the returns concerning the market. It is not uncommon for business financial planners to make subjective adjustments to the historical data that forms the basis of beta factors.

Adjusting for Project Risk

There are methods that business financial planners use to make adjustments for risks inherent in projects in capital budgeting. Such approaches include the following:

- The subjective approach.
- The decision tree.
- The statistical approach.
- Simulation.
- Certainty equivalents.
- Risk-adjusted discount rates.

The subjective approach—This method involves a determination of a project's net present value. A subjective determination is then made as to the risk of a project in view of its calculated anticipated return. The easiest projects to evaluate in this light are those with substantially similar net values, even though the degrees of risk differ.

Decision trees—A matrix or diagram that is often used as the basis for decision making in long-term capital planning or budgeting. The name is appropriate since these diagrams involve horizontal and vertical lines that resemble the trunks and branches of a tree.

Decision trees are simple to use and depict necessary information quite clearly, but they are not considered to be sophisticated tools by business financial planners and analysts. The preparation of a decision tree relies on a great amount of subjective data to assess the probabilities relative to the financial outcome of various, but competing, courses of action. Weighted payoffs for each manner or course of action are added up, allowing the expected value of each to be calculated.

The statistical approach—A corporate financial analyst or planner can assess the trade-off concerning risk-return association with diverse projects by using correlation, a statistical assessment that is combined with other statistical factors, such as expected values of returns and the standard deviation.

By using the method of correlation, a financial planner can select those projects that line up in the best manner with management's preferred risk returns. There are several complex and sophisticated statistical methods known as utility function, which allow for techniques that choose the more suitable projects when viewed in light of risk-return. Utility function is founded more on objective than subjective determinations.

Simulation —Simulation is another complicated and involved statistical method that deals with risk. Cash flows must be generated using random numbers and probability distributions that are fixed. Projected returns on a probability distribution basis can be developed by combining a number of cash flows in a mathematically-based model.

Such random numbers and probability distributions for cash inflows and outflows allow the establishment of a value to be calculated for any variable. The values are then substituted into a mathematical matrix that produces a net present value. In order to obtain a successful probability distribution of net present values, the process must be repeated numerous times, sometimes as frequently as 1,000 times.

A probability distribution of every project's returns, predicated upon the net present value, can be developed by the process of simulating the diverse cash flows relative to a project. By using this method, a business financial planner can assess the expected value of the return and the probability of arriving at such a return. Needless to say, simulation techniques have improved and increased quite dramatically with the growth of computers.

Certainty equivalents—This method is perhaps the most direct means of making adjustments for risks inherent in projects. Certainty equivalents are items that depict what amount or percentage of a projected cash flow a financial planner would exchange for a preferred or expected rate of cash flow.

Adjustments for risk are then made by changing the anticipated funds flow to specific amounts through the use of certainty equivalents, followed by applying a risk-free rate to discount cash flows. This is also a subjective process, but one that is believed to be reasonably sound by financial planners and analysts.

Risk-adjusted discount rates—Risk-adjusted discount rates constitute another method for adjusting for risk where a product is involved that has no efficient market, such as a non-liquid security or investment vehicle. Rather than conforming the cash flows to the factor of risk, the discount rates are instead adjusted. A function must be developed that reflects the required return for every level of risk inherent in a project so that the value is maintained.

A capital asset pricing model cannot be applied to these financial planning or budgeting decisions because the market for the business's project is not efficient enough to allow similar businesses with like products to possess the same information about the product.

Thus, a business must develop the relationship of a specific project or group of assets to other assets held in the business's portfolio. This enables the business to relate various degrees of risk to the return required. A factor of project risk, known as the coefficient of variation, can be utilized to develop a risk-return function or a market indifference curve.

The market indifference curve simply means that cash flows with given levels of risk at similar rates will be discounted by investors. Financial planners must use the correct discount rate so as not to damage the market value of a product. The extent to which the required discount rate is in excess of the risk-free rate is known as the risk premium. Of course, the risk of an investment or a project increases directly with the risk premium.

II. PART II: LONG-TERM CARE POLICIES

THE NEED FOR LONG-TERM CARE

Who Needs Long-Term Care

For the most part, we feel that long-term care is only for the elderly. Quite the contrary. In 2000, there were approximately 8 million Americans, 65 or older, who required long-term care. And by the year 2036, that figure will be 19 million plus!

History of Long-Term Care

Long-term care is not a NOW concept or idea. They first appeared on the scene in the early 1980s but were very primitive and had numerous stipulations, requirements, and exclusions that put them into the "Hit by a cow on the third of the month, providing there was a full moon" category.

Insurance companies were reluctant to get into this market simply because there was no previous claims experience that they could follow. Actuarial science could not be applied, and there were no records on who went into long-term care facilities, when, for what, and how long. Needless to say, this posed major obstacles in the pricing of the product.

WHAT TO LOOK FOR IN LONG-TERM CARE

The most important feature to consider is what type of benefits the policy provides.

The four most common long-term care benefits are as follows:

1. Skilled nursing care.
2. Intermediate care.
3. Custodial care.
4. Home health care.

Let's review each of these so that you completely understand the differences.

Skilled Nursing Care

Skilled nursing care is the most expensive. It requires a prescription from a qualified licensed physician. The care must be continuous on a 24-hour-a-day basis, and you are to be cared for by a Registered Nurse.

Intermediate Care

Although a doctor's prescription is not necessary for this level of care, it does require medical care under the supervision of medical personnel, and it must be administered by a Registered Nurse, Licensed Practical Nurse, or Physical Therapist.

Custodial Care

Custodial care assists the patient in meeting "Activities of Daily Living," also referred to as "ADLs." ADLs are as follows:

- Mobility
- Dressing
- Personal Hygiene
- Eating

Home Health Care

Under this care, the patient is not confined to a nursing home and is usually able to care for themselves. Usually, a non-medical type of person assists in shopping, meal preparation, and some physical therapy.

Optional Benefits

Two of the more common optional benefits are:

- Hospice
- Adult Daycare
- Inflation Protection
- Waiver of premium

Hospice

This provides the terminally ill with comfort in their last days and does not prolong treatment or employ life-saving devices. Typically, a hospital bed is set up in the patient's home to keep them in familiar surroundings with family members during their last days. Depending on the severity of pain or medical needs, home visits are made by Registered Nurses as well as Social Workers. This is a wonderful organization that provides care for the rich and poor and truly does make the last days as comfortable as possible.

Adult Day Care

This care is usually given at a center that caters to those who are mentally or physically impaired. A typical day at the center provides social activity, medical care, meals, and transportation to and from their home.

Inflation Protection

An important option is the inflation protection it provides for future increases in the daily benefit. Most policies offer a 5 percent increase in the daily benefit each year. Long-term care is not immune to inflation, and it is a safe assumption that nursing home care is going to rise.

Waiver of Premium

While optional, most companies include waiver of premium as a standard provision. Typically, once the company has confined you.

How Long Will Benefits Be Paid

This depends entirely on the type of policy the insured purchased. The cost factor also enters into this question. Most companies offer benefits of from one to five years, some even for a lifetime.

Pre-Existing Conditions

Most policies make provisions for pre-existing conditions. Most pre-existing conditions are measured by excluding any condition for which you were treated or given medical advice for the period of six months prior to the effective date of coverage. Additionally, the pre-existing clause continues for six months following the effective date of the policy. So, in reality, you are looking at a year.

Exclusions

You must be aware of the exclusions that long-term care policies contain. Claim time is not when you want to find out. In the early long-term care policies, they would exclude Alzheimer's disease by saying that "the policy excludes diseases of an organic nature," which was their way of excluding Alzheimer's without mentioning the disease by name. This has since been rectified because Alzheimer's disease and other organic diseases are now covered in most policies that we have seen.

Here are some of the more common exclusions:

- Care given in a Veteran's hospital.
- Losses that Workers' Compensation provides for.
- Mental psychoneurotic, or personality disorders that are not the result of organic or physical disease.
- War.
- Intentional self-inflicted injuries.

Long-Term Care Policy Riders

It is now possible to purchase a life insurance policy or a disability income policy and add long-term care as a rider. The rider is very much like the standard long-term care policy in that it affords you the same elimination periods, benefits periods, and levels of care.

Living Benefit Long-Term Care Rider

This rider permits terminally ill patients to use life insurance proceeds in advance to cover expenses connected with their illness. Typically, this option will make available to the insured 70 to 80% of the death benefit they are entitled to cover the cost of nursing home care. Another option in this category is receiving 90 to 95% of the death benefit they are entitled to because they are terminally ill.

UNDERWRITING & LONG-TERM CARE POLICIES

Sources of Information

The underwriting process employs four important sources of information.

- The application.
- The agent.
- Verification reports.
- Medical records and history.

The Application

The application provides the company with the basis upon which they will make the decision to issue a contract. Questions need to be answered in full with honesty and integrity.

The Agent

Years ago, you were permitted to take applications by mail or phone, so long as the applicant signed them. Today, however, companies want to know that the agent actually sees the applicant and assists in the field underwriting. You will be able to make observations unavailable to the home office underwriter.

Verification Reports

The verification reports provide investigative information to verify statements made by the applicant. These reports also sometimes produce additional information or problems that may not have been listed on the application.

Medical Records and History

Oftentimes, companies employ the Medical Information Bureau (MIB) as well as Attending Physicians' Reports (APRs) in verifying medical records and history. This information is extremely important in the underwriting process.

Substandard Underwriting

Not all applications are approved as submitted or issued standard. Often, the applicant is required to pay more than the standard premium for the company to absorb certain hazards or risks.

Factors that directly affect whether the policy will be issued standard or substandard are:

- Pre-existing conditions
- Age
- Occupation (if applicable)
- Moral issues
- Current, past, and possible future medical conditions

GUIDE TO LONG-TERM CARE

The following information was reprinted from *A Shopper's Guide to Long-Term Care,* developed by the National Association of Insurance Commissioners (NAIC) to aid in the purchase of long-term care insurance. These guides are developed to give the potential client sufficient information about their options concerning long-term care insurance.

A Shopper's Guide to Long-Term Care

I. What is Long-Term Care?

Long-term care involves a wide variety of services for people with a prolonged physical illness, disability, or cognitive disorder (such as Alzheimer's disease). Long-term care is not one service, but many different services aimed at helping people with chronic conditions compensate for limitations in their ability to function independently.

Long-term care differs from traditional medical care as it is designed to assist a person to maintain their level of functioning, as opposed to care or services that are designed to rehabilitate or correct certain medical problems. Long-term care services may include, but are not limited to, help with daily activities at home, such as bathing and dressing, respite care, home health care, adult day care, and care in a nursing home.

People with physical illnesses or disabilities often need hands-on assistance with activities of daily living. People with cognitive impairments generally need supervision, protection, or verbal reminders to accomplish everyday activities.

The delivery mechanisms for long-term care services are changing very rapidly; however, skilled care and personal care remain the most common terms used to describe long-term care and the level of care a person may need.

Skilled care is generally needed for medical conditions that require care by skilled medical personnel, such as registered nurses or professional therapists. This care is usually provided 24 hours a day, is ordered by a physician, and involves a treatment plan. Skilled care is generally provided in a nursing home, but may also be provided in other settings, such as the patient's home with help from visiting nurses or therapists. *Note*: Medicare and Medicaid have their own definitions of skilled care. Please refer to *The Guide to Health Insurance for People With Medicare* or *The Medicare Handbook* to find out how Medicare defines skilled care. Contact your local social services office for questions regarding the Medicaid definition of skilled care.

Personal care (also known as custodial care) helps a person perform activities of daily living, which include assistance with bathing, eating, dressing, toileting, continence, and transferring. It is less intensive or complicated than skilled care, and can be provided in many settings, including nursing homes, adult day care centers, or at home.

There are different types of providers of long-term care and places where you can receive this care. State laws governing the providers of long-term care vary widely, as do terms used to describe these providers. As you begin your evaluation of the need for long-term care insurance, you will hear about nursing homes, adult day care centers, assisted living facilities, and home care agencies as some of the many types of long-term care providers.

II. How Much Does Long-Term Care Cost?

Long-term care can be expensive, depending on the amount and type of care needed and on the setting in which it is provided. According to the NAIC, in 1996, the cost of a year in a nursing home averaged about $38,000. (This cost is only an average and varies widely across the country.) If you received skilled nursing care in your own home and were visited by a nurse three times a week for two hours per visit for the entire year, the bill would have come to about $12,300. If you received personal care in your home from a home health aide three times a week for a year, with each visit lasting two hours, the bill would have amounted to about $8,400.

III. Who Pays for Long-Term Care?

The NAIC reports that nationally, one-third of all nursing home expenses are paid out-of-pocket by individuals and their families, and about half are paid by state Medicaid programs.

Long-term care expenses are generally *not* paid for by Medicare, Medicare supplement insurance, or the major medical health insurance provided by most employers. Medicare will cover the cost of some skilled care in approved nursing homes or your home, but only in certain situations.

Further, Medicare's skilled nursing facility (SNF) benefit does not cover general "nursing home" care. The SNF benefit is a "post-hospital" benefit that only covers a relatively intensive level of skilled care furnished during a brief convalescent period after an acute care stay in a hospital. Medicare does not cover homemaker services.

Medicare does not pay for custodial care provided by home health aides unless the individual is also receiving skilled care, such as nursing or therapy, and the custodial care is related to the treatment of the illness or injury. However, there are limits on the number of days and hours of care an individual can receive in any week.

Medicare supplement insurance is private insurance designed to help pay for some of the gaps in Medicare coverage, such as hospital deductibles and excess physicians' charges. These policies do not cover long-term care expenses. However, of the standardized Medicare supplement policies, Plans D, G, I, and J contain an at-home recovery benefit that may pay up to $1,600 per year for short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

Medicaid pays for nearly half of all nursing home care. Medicaid may also pay for some community-based services. To receive Medicaid assistance, you must meet federal poverty guidelines for income and assets, and may have to "spend down" or use up most of your assets on health care. (Some assets, such as your home, may not be counted when determining Medicaid eligibility.) When you have spent down your assets, you will then be eligible for Medicaid. Many people begin paying for nursing home care out of their own pockets and spend down their financial resources until they become eligible for Medicaid. They then turn to Medicaid to pay part or all of their nursing home expenses.

State laws differ on how much money and assets you are allowed to keep once you become eligible for Medicaid. Contact your state Medicaid office, office on aging, state department of social services, or local Social Security office to learn about the rules in your state. In most states, the health insurance counseling and assistance program may also provide some Medicaid information.

IV. Should You Buy Long-Term Care Insurance?

Not everyone should buy a long-term care insurance policy. For some, a long-term care policy is an affordable and attractive form of insurance. For others, the cost is too great, and the benefits they can afford are insufficient. You should not buy a long-term care policy if it will cause a financial hardship and make you forego other, more pressing financial needs. Each person should carefully examine their needs and resources to decide whether long-term care insurance is appropriate. It is also a good idea to discuss such a purchase with your family.

The need for long-term care can arise gradually as a person needs more and more assistance with activities of daily living, or the need can surface suddenly following a major illness such as a stroke or a heart attack.

Some people who have acute illnesses may need nursing home or home health care for only short periods. Others may need these services for many months or years. It is difficult to predict who will need long-term care, but there are studies that help shed some light on the likelihood of needing such care. For example, one national study projects that 43 percent of those who turned age 65 in 1990 will enter a nursing home at some time during their lives. The same study reported that among all persons who live to age 65, only 1 in 3 will spend three months or more in a nursing home; about 1 in 4 will spend one year or more in a nursing home; and only about 1 in 11 will spend five years or more in a nursing home.

In other words, two out of three people who turned 65 in 1990 will either never spend any time in a nursing home or will spend less than three months in one.

Also, according to the NAIC, the risk of needing nursing home care is greater for women than men; 13 percent of the women in this study, compared to 4 percent of the men, are projected to spend five or more years in a nursing home. The risk of needing nursing home care also increases with age.

The chances of needing home health care are substantially greater than needing nursing home care.

Once you have assessed your odds of needing coverage, you should take a hard look at the reasons you want a policy and your ability to pay for it.

Whether you should buy a policy will depend on your age, health status, overall retirement objectives, and income. For instance, if your only source of income is a Social Security benefit or Supplemental Security Income (SSI), you should probably not purchase long-term care insurance. Also, if you have trouble stretching your income to meet other financial obligations, such as paying for utilities, food, or medicine, you should probably not purchase a long-term care insurance policy.

On the other hand, people with significant assets may wish to buy a long-term care policy if they want to save these assets. Many people buy a long-term care insurance policy because they want to pay for their own care and not burden their children with nursing home bills. However, you should not buy a policy if you can't afford the premiums or cannot reasonably predict that you will be able to pay the premiums for the rest of your life.

If you have existing health problems that are likely to result in the need for long-term care (Alzheimer's disease or Parkinson's disease, for example), you will probably not be able to buy a policy. Insurance companies have medical underwriting standards in place to keep the cost of long-term care insurance affordable. In the absence of such provisions, most people would not buy coverage until they needed long-term care services.

V. Who Sells Long-Term Care Insurance?

Private insurance companies sell long-term care insurance policies. They may sell them to individuals through agents or sometimes through the mail without using agents. Some companies sell coverage through senior citizen organizations, fraternal societies, and other groups or associations. Many employers now make long-term care insurance policies available to their employees, their employees' parents, and their retirees.

Insurance companies must be licensed in your state to sell long-term care insurance. Be certain that you are dealing with a company that you know. If you decide to purchase long-term care insurance, be sure that the company and the agent, if one is involved, are licensed in your state. If you are not sure, contact your state insurance department.

You may also be able to purchase a long-term care insurance policy through a continuing care retirement community (CCRC). A CCRC is a retirement complex that provides a broad range of services. If you are a resident or are on the waiting list of a CCRC, you may be offered the opportunity to enroll in a group long-term care insurance policy.

The coverage provided by the long-term care insurance policy is similar to other group or individual policies and is usually designed to complement the fee structure of the continuing care retirement community. Individual medical screening, or underwriting, is often required when a resident applies for this type of long-term care insurance coverage.

VI. What Kind of Policies Can You Buy?

Today, long-term care insurance policies are not standardized like Medicare supplement insurance. There are several companies selling policies with multiple combinations of benefits and coverage. There are also several ways to acquire a policy. You may do so individually, through your employer or your spouse's employer (and in some cases, your children's employers), through membership in an association, and even through a life insurance policy.

A. Individual Policies — Most of the policies sold today are sold to individuals. Many of these policies are sold through insurance agents, but some are also sold through mail solicitations or direct telemarketing. Individual policies offer a wide variety of coverage; however, not all companies offer the same coverage. You may have to shop among companies and agents to get the coverage that best fits your needs.

B. Policies From Your Employer — Your employer may provide you with an opportunity to enroll in a group long-term care insurance plan. The coverage provided by these employer-group policies is similar to what you could buy in an individual policy from an agent or through direct mail solicitation. Insurers may allow you to keep your coverage after you leave your employer. They do this by offering continuation of coverage or conversion options. Many employers also allow retirees, spouses, parents, and parents-in-law to buy coverage. Typically, employees' spouses, parents, and parents-in-law must pass the company's medical screening to qualify for coverage. Employees may not have to pass any medical requirements. If an employer offers such coverage, be sure to consider it carefully. An employer group policy may offer options you won't find if you try to buy a policy on your own.

C. Association Policies — Many associations allow insurance companies and agents to offer long-term care insurance to their members. These policies are quite similar to other types of long-term care insurance policies. Like policies that employers offer, association policies usually give their members a choice of benefit periods, maximum payments, and elimination periods. Association policies may offer non-forfeiture benefits and inflation protection. In most states, association policies must allow members to keep their coverage after they leave the association. You should be cautious about joining an association for the sole purpose of purchasing any insurance coverage, especially long-term care coverage.

D. Life Insurance Policies — Some life insurance companies offer access to the life insurance death benefit and cash value under certain specified conditions prior to death, such as terminal illness, permanent confinement in a nursing home, or for long-term care. This is often referred to as an "accelerated benefit" provision. Long-term care benefits can be offered as a feature of an individual or group life insurance policy. Under these arrangements, a portion of the policy's death benefit is paid periodically when the insured needs long-term care services. Policies may pay up to 100 percent of the death benefit for long-term care, and some companies offer the option to purchase additional long-term care coverage beyond the death benefit amount.

It is important to remember that the amounts used under this type of coverage reduce the amount of death benefit the beneficiary will receive, as well as the cash value of the life policy. For example, if you purchase a policy with a $100,000 death benefit and use $60,000 for long-term care, the death benefit of your policy will be reduced to $40,000. If you purchase life insurance to provide a benefit upon your death for a specific need, and you use this option for long-term care needs, the benefit upon your death may not cover this original need. If you never use the long-term care benefit, the full death benefit stated in your life insurance policy will be paid to your beneficiary.

E. **Partnership Programs —** Some states have programs designed to assist persons with the financial consequences of spending down to Medicaid eligibility standards. These programs, generally called "partnerships," allow persons to purchase certain qualified long-term care insurance policies from insurance companies and receive full or partial protection against the normal Medicaid spend-down of assets. Please keep in mind that "partnership" programs are specific to that particular state, and that you must be a resident of that state once the policy benefits are exhausted, and you are ready to apply for Medicaid assistance.

VII. How Policies Work

A. What's Covered?

If you buy a long-term care policy, it is critical that you understand the coverage for the variety of long-term care services available. Some policies cover only stays in nursing homes. Others cover only care in your home. Still others cover both nursing home and home care. In addition, many policies also cover services provided in adult day care centers or other community facilities.

Many long-term care policies will only pay for care provided in licensed nursing facilities. Most policies on the market today do not distinguish among the types of nursing home care or the level of care that is provided. They will pay for any care you need, provided, of course, you need long-term care and meet other eligibility requirements contained in the policy, which are explained later in this guide.

Home care coverage varies. Some policies pay home care benefits only for home care performed in your home by registered nurses, licensed practical nurses, and occupational, speech, or physical therapists. Many policies offer a broader range of home care benefits coverage. For instance, the services of home health aides employed by licensed home care agencies may be covered. These aides have less training than nurses who perform skilled care, and they generally help patients with personal care. You may find a policy that pays for homemaker or choreworker services. This type of policy, though rare, would pay for someone to come to your home and cook meals and run errands. Generally speaking, adding home care benefits to the policy will raise the cost.

Note: Most policies don't pay benefits to family members who may perform home-care services.

B. How Are Benefits Paid?

Insurance companies generally pay benefits in two different methods: the expense-incurred method and the indemnity method.

In the expense-incurred method, once you have been determined to be eligible for benefits and you submit claims, the insurance company either pays you or the provider up to the limits contained in the policy. Your policy or certificate will pay benefits only when eligible services are received.

The second type of benefit payment is the indemnity method. Under this method, once you have been determined to be eligible for benefits, the insurance company will pay you benefits directly in the amount specified in the policy, without regard to the specific services received.

It is important to read the literature that accompanies your policy or certificate. Most of the policies purchased currently pay benefits by the expense-incurred method. The difference between the two types of policies lies in the way benefits are paid. Expense-incurred policies pay benefits either to you or to the provider, while indemnity policies normally pay benefits directly to you only. (Expense-incurred policies tend to be less expensive, but also tend to provide benefits for a longer period.)

C. Where Is Service Covered?

With a long-term care policy, it is not enough to know what services are covered. You also need to know where services are covered. If you are not in the right type of facility, the insurance company can refuse to pay. Some policies provide for care in any state-licensed facility.

Others may limit the kinds of facilities where you can receive care. For example, many will not cover personal care unless it is provided in a licensed nursing facility. Others list by name the kinds of facilities where you will not be covered. These often include homes for the aged, rest homes, personal care homes, and assisted living facilities, although many states license these facilities to provide custodial care. Some policies may explicitly define the kinds of facilities that they will cover.

Some will say the facility must care for a certain number of patients or require a certain kind of nursing supervision. It is important to check these requirements very carefully and pay particular attention to the types of facilities that provide services in your area. It is important that you contact your insurance company before entering the healthcare facility to determine if the stay will be covered.

D. What's Not Covered?

Generally, insurance companies do not pay benefits if services are needed for a person who has:

- A mental or nervous disorder or disease, other than Alzheimer's disease;
- An alcohol or drug addiction;
- An illness or injury caused by an act of war;
- Had treatment already paid for by the government, or;
- Attempted suicide or intentionally self-inflicted injuries.

Note: Insurance carriers cannot exclude coverage for Alzheimer's disease in states that have adopted the National Association of Insurance Commissioners' Long-Term Care Insurance Model Regulation. Virtually all policies specifically say they will cover Alzheimer's disease. You should also be aware of the connection between Alzheimer's disease and eligibility for benefits.

E. How Much Coverage Will You Have?

The amount of coverage provided by your policy or certificate is expressed in different ways. Be sure you understand the amount of coverage you have in your policy or certificate. Also, keep in mind that the type of service received will dictate the amount of coverage, and that the amount of coverage may vary depending on the type of service you receive.

When you buy a policy, you will also be asked to choose a benefit period— that is, how long you want your benefits to last. Benefit periods may run for one year, two years, four years, six years, ten years, and sometimes for the rest of a policyholder's life.

1. Lifetime Maximum Benefits —

Most plans have a total maximum benefit they will pay out over the length of the policy's duration. The maximum benefit limit is generally expressed in language similar to: "total lifetime benefit," "maximum lifetime benefit," or "total plan benefit." When you are examining a policy or certificate, be sure you carefully consider the total amount of coverage you will have available. A few plans offer unlimited lifetime benefits. Often, these benefits are expressed in the marketing materials as benefit periods of one, two, three, or more years, or total dollar amount available. Which is better — a longer or a shorter benefit period? Most nursing home stays are short — three months or less — but some illnesses can go on for several years, necessitating very long stays. You will have to decide whether you want to be protected for such catastrophic events, bearing in mind that policies with longer benefit periods tend to cost more.

2. Daily/Monthly Benefit Amounts —

Benefits are often payable on a daily, weekly, monthly, annual, or other basis. For example, in an expense-incurred plan, a nursing home benefit might be paid daily in an amount up to $100 per day, while a home care benefit might be paid on a weekly basis of up to $350 per week for approved home care services. Some policies include single-event benefits, such as a single payment for the installation of a home medical alert system. Insurance companies offer you a choice of periodic benefit amounts (usually $50 to $250 a day, or $1,500 up to $7,500 a month) for care in nursing homes. It is important to know how much nursing facilities in your area charge before you select a benefit amount for your policy. If home care is a covered benefit included in your policy, the benefit for those services is normally half or some other percentage of the benefit for nursing home care.

***Note*:** For home care coverage, the benefit period may be different from the benefits for nursing home stays, though in some policies it may be the same or longer.

F. When Are You Eligible for Benefits? *(Benefit Triggers)*

All policies contain provisions that determine if and when benefits are payable. The provisions that companies use to determine benefits, sometimes called "benefit triggers," are generally contained in a section of the policy and outline of coverage entitled "Eligibility for the Payment of Benefits" or simply "Eligibility for Benefits." How a company determines when benefits are payable is an important feature of a long-term care policy, and one you should pay careful attention to as you shop. There might be a wide variation among policies when it comes to these provisions. Some policies use more than one provision to determine when benefits are payable. Some states have specific benefit trigger requirements. Check with your state insurance department to find out what is required in your state.

1. Activities of Daily Living

The most common method for determining when benefits are payable is based on the insured's inability to perform activities of daily living, commonly known as ADLs. Generally speaking, the most common ADLs used by insurance companies are bathing, continence, dressing, eating, toileting, and transferring. Typically, benefits are payable when a person is unable to perform a certain number of the ADLs, such as three of the six or two of the six.

***Note*:** The six ADLs have been developed through years of research. This research also has shown that bathing is usually the first ADL that a person is unable to perform. If a policy only uses five ADLs and bathing is not included, it may be more difficult to qualify for benefits through that policy than through a policy that includes the bathing ADL.

2. Cognitive Impairments

Many policies also have a provision for "cognitive impairment" or mental incapacity. This type of provision generally provides benefits if the insured is unable to pass certain tests assessing their mental function. This provision is especially important if a person has Alzheimer's disease. Most states prohibit policies from containing an exclusion for Alzheimer's disease.

However, a policyholder who has Alzheimer's disease may not qualify for benefits if they are physically able to perform the activities of daily living specified unless the policy has a provision for cognitive impairment or mental incapacity. If the policy uses only an ADL benefit trigger, those with Alzheimer's disease may not qualify for benefits. But if a policy also has a benefit trigger for cognitive impairment or mental incapacity, an insured with the disease is more likely to receive benefits.

3. Doctor Certification of Medical Necessity

Under some policies, you'll qualify for benefits if your doctor orders or certifies that the care is medically necessary. If you need personal care in a nursing home, but are not sick or injured, you may not qualify for benefits under a medical necessity requirement, depending on how the policy defines medical necessity.

4. Prior Hospitalization

Some policies sold several years ago required the insured to have a prior hospital stay of at least three days before qualifying for benefits. This requirement is very restrictive and can severely limit your ability to receive any benefits from your policy. This type of provision is prohibited in the current NAIC model law. Most states now prohibit policies from requiring a prior hospitalization. However, a few states still permit insurance companies to use this benefit trigger.

***Note*:** The provisions for benefits that companies use for home care coverage may be different from those for nursing home care.

G. When Do Benefits Begin? *(Elimination Period)*

With many policies, your benefits won't begin the first day you enter a nursing home or begin using home care. Most policies include an elimination period (sometimes called a deductible or a waiting period). That means benefits begin 20, 30, 60, 90, or 100 days after you enter a nursing home, depending on the elimination period you pick when you buy your policy. You might be able to choose a policy with a zero-day elimination period, but these also tend to cost more.

Some companies may not give you the option of selecting such an elimination period. Of course, during the elimination period, you'll have to cover the cost of long-term care services yourself. Elimination periods may be shorter for home care benefits.

In choosing an elimination period, you'll have to weigh the trade-off between paying a higher premium for a shorter elimination period. If a nursing home in your area costs $80 a day, a policy with a 30-day elimination period will require you to pay $2,400 out of pocket, a policy with a 60-day period will require $4,800 of your own money, and a policy with a 90-day elimination period will cost $7,200 of your own money.

If your stay is short and you have a policy with a long elimination period, you may not receive any benefits from your policy. On the other hand, if you can afford to pay for a short stay, a longer elimination period might be in order. In this manner, you'll be protected if you have a prolonged nursing home stay, and at the same time, keep the cost of your insurance down.

You may also want to consider how the policy pays if you have a repeat stay in a nursing home. Some policies require you to be out of a facility for a certain period of time before you can receive benefits for a second stay. Others will consider the second stay as part of the first one as long as you are released and then readmitted within 30, 90, or 180 days. You need to find out if the insurance company requires the elimination period to run again for a second stay. Keep in mind that repeat nursing home stays are not typical, so you may not want to put a lot of emphasis on this feature as you do your shopping.

H. What Happens When Long-Term Care Costs Rise? *(Inflation Protection)*

Inflation protection can be one of the most important additions you can make to a long-term care policy. However, inflation protection adds to the cost of the policy. Unless your policy provides for inflation for your daily benefit to increase over time, years from now, you may find yourself owning a policy whose benefit has not kept pace with the increasing costs of long-term care. A nursing home that costs $86 a day now will cost $228 in 20 years, assuming an inflation rate of 5 percent a year. The younger you are when you purchase a policy, the more important it is for you to consider adding inflation protection.

There are two ways that inflation protection is most commonly offered. The first automatically increases your benefits each year. The second allows you the option to increase your benefits periodically, such as every three years. Be sure you understand the implications of accepting or rejecting an opportunity to increase the inflation protection benefits of your policy.

Two types of increases are generally made available: simple and compounded rate increases. Under both, the daily benefit increases annually by a fixed percentage, usually 5 percent, for a certain period, usually 10 or 20 years. Even though the automatic increases are a fixed percentage amount, the dollar amount of the increases from year to year will differ, depending on whether the inflation adjustment is "simple" or "compounded."

If the inflation adjustment is simple, the dollar amount of the increase added to the benefit stays the same every year. If the adjustment is compounded, the benefit increases by an increasing dollar amount from one year to the next. For example, an $80 daily benefit that increases by a simple 5 percent a year will provide $160 a day in 20 years, but if it's compounded, it will provide $212 a day. It is desirable to choose a policy with automatic increases that are compounded, but some policies do not provide for that. Some states now require that inflation increases be compounded. Compounding can make a large difference in the size of your benefit.

Note: The NAIC model regulation requires companies to make an offer of inflation protection, leaving it up to you to decide whether to buy the coverage. Most states have adopted this provision. If you decline, you will be asked to sign a statement saying you don't want the inflation protection. Be sure you understand what you are signing.

I. What Other Optional Policy Provisions May Be Available?

Other options may be available. These optional features may add to the cost of the policy. Ask your insurer what features add to the cost of the policy.

1. Third Party Notification

This benefit allows you to name a third party who would be notified by the insurance company if the policy is about to lapse because of the non-payment of the premium. The third party can be a relative, a friend, or a professional (a lawyer or an accountant, for example). This third party, after they have been notified, would then have a time to pay the overdue premium. Individuals with cognitive impairments who have forgotten to pay the premium have had their policy lapse when they have needed it the most. If you select this provision, a lapse can be prevented. You can generally designate a third party at no additional cost to you. Some states now require that the insurance company provide you with the opportunity to name a third party and may even require that you sign a waiver if you elect not to name anyone to be notified if the policy is about to lapse.

2. Waiver of Premium

This provision allows you to stop paying premiums once you are in a nursing home or you are receiving care at home, and the insurance company has started to pay benefits. Some companies waive the premium as soon as they make the first benefit payment, while others wait 60 to 90 days. Waiver of premium may not apply if you are receiving care in your home.

3. Restoration of Benefits

This benefit provides for the maximum amount of your original benefit to be restored, even if you have previously received benefits through your policy. Generally, if you receive long-term care benefits and then go for a stated period without receiving long-term care services, the amount of your benefit reverts back to the amount you originally purchased. For example, if you used $5,000 of long-term care benefits that were paid for by your policy (out of a maximum available amount of $75,000), and thereafter used no long-term care services for a specified period, the $5,000 would be restored back to the maximum amount of benefit you would have available. Instead of having only $70,000 of benefits remaining, you would have the original $75,000 benefit available.

4. Nonforfeiture Benefits

This benefit returns to you some of the investment (through the premiums paid) in the policy if you drop your coverage. Without this type of benefit, you receive nothing if you drop the policy 10 or 20 years later.

Some states may require the offer of nonforfeiture benefits. There are several types of non-forfeiture benefits, and each has a different premium associated with it. A company may offer a nonforfeiture benefit by giving you a reduced paid-up policy.

This coverage generally provides the same daily benefit purchased for a reduced period based on the number of years the policy was in premium-paying status. Other carriers may offer a "return of premium" benefit under which they return all or a portion of the premiums after a certain number of years if you drop your policy. This is generally the most expensive type of benefit.

A nonforfeiture benefit can add roughly 10 to 100 percent to a policy's cost, depending on such things as your age at the time of purchase, the type of nonforfeiture benefit offered, and whether the policy provides for inflation protection.

5. Premium Refund Upon Death

This benefit refunds to your estate any premiums paid minus any benefits the company paid. To receive a refund at death, you must have paid premiums for a certain number of years. In some policies, death benefits are payable only if the policyholder dies before a certain age, usually 65 or 70. Death benefits may also add to the cost of a policy.

VIII. Will Your Health Affect Your Ability to Buy a Policy?

Companies selling long-term care insurance "underwrite" their coverage. That means they look at your health and health history before they will issue a policy. Some companies do what is known as "short-form" underwriting. On the application for coverage, they will ask you to answer a few questions about your health; for example, they may want to know if you have been hospitalized in the last 12 months or are confined to a wheelchair.

Some companies conduct more extensive underwriting. They may examine your current medical records and ask for a statement about your health from your doctor. These companies may be more selective about whom they'll insure. Having certain conditions that are likely to require a nursing home stay in the near future (Parkinson's disease, for example) probably will disqualify you for coverage at these companies. In either case, you must answer certain questions that the company uses to determine if it is going to issue the coverage. Some group policies, especially those available through an employer, may be available without any underwriting requirements.

No matter what kind of underwriting a company uses, it is very important to answer all health questions truthfully. If a company later learns you did not fully disclose your health status on the application, and the company relied on the misstatement to grant coverage, it can rescind, or cancel, your policy and return the premiums you've paid. It usually can do this within two years after you buy the policy.

Sometimes companies do not investigate your medical record until you file a claim, and then they may attempt to deny benefits based on inconsistencies. This practice is called "post-claims underwriting" and is illegal in many states. Companies that thoroughly check on your health before issuing a policy are not as likely to engage in post-claims underwriting.

Most states require the insurance company to provide you with a copy of the application you completed when you applied for coverage. You should review the application and be certain that you have answered all health questions truthfully and that the information you provided to the company is accurate.

What Happens if You Have Preexisting Conditions? Many companies will usually issue a policy to people who have relatively minor health problems. The company may not pay benefits for conditions related to these minor health problems, or pre-existing conditions, for a period of time after the effective date of the policy, usually six months. Some companies have longer pre-existing conditions periods; others have none. A preexisting condition is normally defined in the policy as one for which you sought medical advice or treatment or had symptoms within a certain period before applying for the policy.

Companies also vary in the length of time they will look back at your health status, and you will want to consider these variations as well. If the company discovers you have not disclosed a preexisting condition on your application, it may refuse to pay for treatment related to that condition and perhaps terminate your coverage.

IX. Can You Renew Your Coverage?

In most states, the laws require that policies currently sold be guaranteed renewable. When a policy is guaranteed renewable, it means that the insurance company guarantees that it will offer you the opportunity to renew the policy and maintain the coverage. It does not mean that you are guaranteed the opportunity of renewing at the same premium.

Premiums may rise over time as companies pay claims in greater amounts and frequency. However, once you buy a policy, the premiums won't rise just because you get older. Keep in mind that insurance companies cannot raise the premiums on any individual policy. They must raise the premiums on all policies of the same class in your state. If you have purchased this policy in a group setting and you leave the group, you may be able to convert your coverage from the group policy to an individual policy, or continue your coverage under the group policy.

X. What Do Policies Cost?

A long-term care policy can be expensive, and you might want to be sure you can pay the premium for it as well as premiums for your other health insurance which you also consider to be important. The annual premium for long-term care policies with inflation protection can run as much as $2,000 for someone age 65. The premium will be lower for those who are younger and higher for those who are older.

If you purchase a policy at age 75, the premium will generally be two- and one-half times greater than if you had bought the policy at age 65. It will be six times higher than if you bought it at age 55. It's not unusual for a couple aged 65 to spend around $7,500 for all their health insurance coverage. If you buy a policy with a large daily benefit or a longer benefit period, it will also cost you more. Inflation protection can add 25 to 40 percent to the premium. Non-forfeiture benefits can add 10 to 100 percent to the premium.

When buying a long-term care policy, you must consider not only whether you can continue to pay the premium now, but also if you will be able to continue to pay the premiums in the future, when they most likely will be higher. Premiums on these policies may increase. Insurance companies can raise the premiums on their policies, but only if they increase the premiums on all policies of that class in that state. No individual can be singled out for a rate increase, regardless of the number of claims that they have incurred. Some states have rate increase restriction laws.

Consider how much income you have and how much you could afford to spend on a long-term care policy now. Also, try to project what your income is likely to be in the future, what your living expenses will be, and how much you can pay for long-term care insurance premiums. If you don't expect your income to increase, it probably would not be wise to purchase a policy now with a premium that is at the upper limit of what you think you can afford.

***Note*:** Don't be misled by the term "level premiums." Some persons or entities marketing long-term care insurance might tell you that your premium is level and imply that it will never rise. Except for "whole life" insurance policies, companies cannot guarantee their premiums will never increase. The NAIC model prohibits insurance companies from using the word "level" in connection with the sale of guaranteed renewable policies. Many states have adopted this provision. New rules require companies to tell prospective customers that the premiums on their policies may go up.

XI. If You Already Own a Policy, Should You Switch Plans or Upgrade Existing Coverage?

Before you buy a new policy, make sure it is better than the one you already have. Even if your agent has switched companies, carefully consider any changes. If you decide to switch, make sure your new application is accepted and the policy is issued before you cancel the old policy.

If you cancel a policy in the middle of its term, most companies will not return any premiums you have paid. If you switch policies, new restrictions on preexisting conditions may apply, and you may not have coverage for certain conditions for a specific period of time. Some states do not allow a new preexisting condition waiting period for similar benefits if you switch policies. The new waiting period will apply to new benefits only.

It may be appropriate to switch, however, if you have an old policy with requirements for a prior hospital stay or for prior levels of care, and you are in good health and can qualify for another policy. If you have a good policy you bought when you were younger, you might ask if the insurance carrier can enhance the policy, for example, by adding inflation protection or removing the pre-hospitalization requirement. It might be cheaper to keep the policy you have and improve it rather than buy a new one.

XII. What Shopping Tips Should You Keep in Mind?

Here are some points to keep in mind as you shop:

A. Ask questions.

If you have questions about the agent, the insurance company, or the policies, contact your state insurance department or senior counseling program.

B. Check with several companies and agents.

It is wise to contact several companies (and agents) before you buy. Be sure to compare benefits, the types of facilities you have to be in to receive coverage, the limitations of coverage, the exclusions, and, of course, the premiums. (Policies that provide identical coverage and benefits may not necessarily cost the same.)

C. Take your time and compare the outlines of coverage.

Never let anyone pressure or scare you into making a quick decision. Don't buy a policy the first time an agent comes calling. Ask the agent to give you an outline of coverage. The outline of coverage summarizes the policy's benefits and highlights important features. Compare outlines of coverage for several policies.

Most states require the producer to leave an outline of coverage at the time the agent initially contacts you. If the agent does not give you an outline or tells you they will provide it later, do not deal with that agent.

D. Understand the policies.

Make sure you know what the policy covers and what it does not. If you have any questions, ask the agent or call the insurance company's home office before you buy.

If the agent gives you answers that are vague or differ from information in the company literature, or if you have doubts about the policy, tell the agent you will get back to them later, and don't hesitate to call or write to the company and ask your questions. Beware of sales solicitation that claims the policy can be offered only once.

Some companies may sell their policies through the mail, bypassing agents entirely. If you decide to buy a policy through the mail, contact the company if you don't understand how the policy works.

Discuss the policy with a friend or relative. You may also want to contact your state insurance department or your state's insurance counseling program.

E. Don't be misled by advertising.

Don't be misled by the endorsements of celebrities. Most of these people are professional actors who are paid to advertise. They are not insurance experts.

Neither Medicare nor any other federal agency endorses or sells long-term care policies. Be skeptical of any advertising that suggests the federal government is involved with this type of insurance.

Be wary of cards received in the mail that look as if they were sent by the federal government. They may actually have been sent by insurance companies or agents trying to find potential buyers. Be skeptical if you are asked questions over the phone about Medicare or your insurance. Any information you give may be sold to persons or entities marketing long-term care insurance who might call you, come to your home, or solicit you by mail.

F. Don't buy multiple policies.

It is not necessary to purchase several policies to get enough coverage. One good policy is enough.

G. Don't be misled by marketers of long-term care insurance who say your medical history is not important.

Disclosing your medical history is very important. Make sure you fill out the application completely and accurately. If an agent fills out the application for you, don't sign it unless you have read it and made sure that all of the medical information is correct. If information about the state of your health is wrong, and the company relied on it in granting coverage, the company can refuse to pay your claims and can even cancel your policy.

H. Never pay in cash.

Use a check or money order made payable to the insurance company.

I. Be sure to get the name, address, and telephone number of the agent and company.

Obtain a local or toll-free number (if the company has one).

J. If you don't receive your policy within 60 days, contact the company or agent.

When you receive your policy, keep it in a convenient place where you can find it, and tell a trusted friend or relative where it is.

K. Be sure you review your policy during the free-look period.

If you decide you do not want the policy after you purchase it, you can cancel the policy and get your money back if you notify the company within a certain number of days after the policy is delivered. This is called the "free-look" period. Some states require that the insurance company disclose information about the free-look period on the cover page of the policy.

Most states allow policyholders to cancel within 30 days, but some may have a shorter free-look period. If you want to cancel, do the following:

- Keep the envelope the policy was mailed in, or insist that your agent gives you a signed delivery receipt when they hand you the policy.
- If you decide to return the policy, send it to the insurance company along with a brief letter asking for a refund.
- Send both the policy and letter by certified mail and obtain a mailing receipt.

- Keep a copy of all correspondence.
- The refund process usually takes four to six weeks.

L. Read the policy again and make sure it provides the coverage you want.

Reread the application you signed. It becomes part of the policy. If it's not filled out correctly, notify the insurance company right away.

M. It may be a good idea to have premiums automatically deducted from your bank account.

That way, if an illness causes you to forget to pay them, your coverage won't lapse. If you decide not to renew your policy, be sure you contact the bank and stop the automatic withdrawal.

N. Check on the financial stability of the company you're considering.

Several private companies or rating agencies conduct financial analyses of insurance companies and grade them. These ratings carry no guarantee of accuracy but can provide you with information on how some analysts view the health of particular insurance companies. Different agencies use different rating scales, so be sure to find out how the agency labels its highest ratings as well as the ratings for the companies you are considering.

Ratings from some agencies are available at most public libraries, or you can call the agencies directly at the numbers listed below. (Note that there will be an extra charge on your telephone bill for calls to a "900" number.)

- M. Best Company (900) 420-0400
- Duff & Phelps, Inc. (312) 368-3157
- Fitch Investors Service, Inc. (212) 908-0500
- Moody's Investor Service, Inc. (212) 553-1653
- Standard & Poor's (212) 208-1527
- Weiss Research, Inc. (800) 289-9222

For more information, contact the NAIC at 120 W. 12th St., Suite #1100, Kansas City, MO 64105-1925. (Phone (816) 842-3600.)

WHO SHOULD BUY LTC INSURANCE?

Of course, not everyone has an urgent need for long-term care insurance. Thus, not everyone should buy a policy. An important aspect to consider before purchasing long-term care insurance is whether or not it can be afforded. Long-term care insurance should not make an individual undergo financial troubles simply to have a plan in case of future need.

An individual considering the purchase of long-term care insurance should look seriously at their assets to determine if a long-term care policy purchase is a wise investment at the present time. The individual should consider their age, health condition, future plans, and current financial status. If an individual is suffering from an existing condition, it will most likely be rather difficult to obtain a long-term care insurance policy.

But having some form of long-term health care coverage is very appropriate for those people reaching senior adulthood. People without insurance may be forced to enter a facility not right for their needs or a facility they would not normally choose due to the fact that, due to their economic position, they simply cannot afford the costs associated with extended care.

Because of this, a very important reason one should obtain a long-term care insurance policy is so that their assets are protected from the above situation. Because so many people depend on their accumulation of assets after they retire, a definite necessity is ensuring that the money they have worked so hard for all their lives will be there when they need it and will not be wiped out due to an extended illness.

People with low incomes and few (or no) assets are sometimes apt to purchase long-term care insurance. The premiums are frequently rather expensive, and, of course, there is no guarantee that this coverage will ever be used. Thus, many people with low incomes cannot afford long-term care insurance. Sometimes, the people in this situation already qualify for Medicaid, which takes care of any long-term care. Essentially, long-term care insurance policies are not ideal for people with low income and asset levels.

People who are classified as being in the upper or middle economic classes are those most likely to obtain long-term care insurance. Members of these classes earn adequate salaries, and most often are also entitled to insurance and retirement benefits. Due to the fact that they can afford long-term care insurance, it is a good idea for them to have this form of coverage. If an uninsured person happened to suddenly need a form of long-term care, then they could be headed for financial devastation because of the costs associated with the uninsured care.

Long-term care insurance would definitely be appropriate for a person in this type of situation. If it were not for the insurance coverage, the person would most likely be financially ruined in a short time.

Of course, a long-term care policy does not have to cover every exposure for the policyholder to benefit from having the coverage. Lower amounts of coverage may help to reduce the premium payments and, in the process, make the coverage more affordable for the insured.

Individuals with the most to lose from not having long-term care insurance are the most ideal candidates for coverage. As stated previously, if an uninsured individual suddenly faces lengthy medical care for illness or injury, they could go broke struggling to pay for all the costs associated with long-term care.

This also works in reverse situations. If a person has a large amount of income and/or assets which would not be affected by being uninsured and in need of some type of long-term health care, then long-term care insurance may not be an urgent necessity. Successful entertainers fall into this category. These people more than likely would not be financially ruined if they had to have long-term care and did not have the insurance to cover it. These individuals have the economic means to afford almost anything they might encounter.

Of course, long-term care policies could be purchased by individuals with high incomes solely for the protection of their assets. They may want both themselves to be financially well-off or secure, and want their children and the remaining members of their family to be secure as well.

Having long-term care insurance could enable the individual to retain the family assets for the beneficiaries.

III. PART III: WORKERS' COMPENSATION

SECTION I-THE NEED FOR WORKERS' COMPENSATION

Physiological and Safety Needs

A human is a wanting animal (as soon as one need is satisfied, another appears in its place). This process is unending. It continues from birth. Our needs are organized in a series of levels—a hierarchy of importance. At the lowest level, but preeminent in importance when they are thwarted, are physiological needs.

Unless the circumstances are unusual, our needs for love, status, and recognition are inoperative when our stomachs have been empty for a while. But when we eat regularly and adequately, hunger ceases to be an important need. The same is true for other physiological needs of humans—for rest, exercise, shelter, and protection from the elements.

A satisfied need is not a motivator of behavior. This is a fact of profound significance. It is a fact that is regularly ignored. Consider your own need for air. Except as you are deprived of it, it has no appreciable motivating effect upon your behavior.

When the physiological needs are reasonably satisfied, needs at the next highest level begin to dominate our behavior. These are the safety needs. They are needs for protection against danger, threat, and deprivation. The need is for the fairest possible break. A confident person is more willing to take risks. However, when one feels threatened or dependent, the greatest need is for guarantees of protection and security.

The fact needs little emphasis that since every employee is in a dependent relationship with their employer, safety needs may assume considerable importance. In employment relationships, safety needs can be powerful motivators and affect every employment level, from maintenance worker to vice president.

People have always sought security and protection from those factors that have threatened their security. Security has many faces and dimensions. And, since life is full of uncertainty and surrounded by complex threatening forces, the concept of security can be analyzed from several disciplines.

However, a complete analysis of security is a burdensome, if not impossible, task. A narrower view emphasizes economic security with respect to social insurance programs. In that vein, a survey of workers' compensation programs is presented here.

The Nature of Economic Security

Economic security, which is part of our total welfare, can be defined as a state of mind or sense of well-being by which an individual is relatively certain that they can satisfy basic needs and wants, both present and future. The phrase "basic needs and wants" refers to a person's desire for food, clothing, housing, medical care, and other necessities. When a person is relatively certain that both present and future needs and wants can be satisfied, then they may experience a sense of well-being.

The Nature of Economic Insecurity

Economic insecurity is the opposite of economic security; that is, the sense of well-being or state of mind that results from being relatively able to satisfy both present and future needs and wants is lacking. Instead, there is considerable worry, fear, anxiety, and psychological discomfort. The need for money is a constant problem.

Economic insecurity can be caused by a person's losing their income, being forced to assume excessive or additional expenses, or earning an insufficient income. Economic insecurity can also be experienced if there is uncertainty regarding the continuation of future income.

Thus, economic insecurity consists of one or more of the following:

- loss of income,
- additional expenses,
- insufficient income and
- uncertainty of income.

Loss of Income

Regardless of whether the income loss is relative or absolute, economic insecurity is present when the worker's income is lost. In such a case, unless the worker has sufficient financial assets, past savings, or other sources of replacement income, basic needs and wants cannot be satisfied. Moreover, the continuous consumption of goods and services above the poverty line may be difficult because of the income loss.

Additional Expenses

Economic insecurity can also result from additional expenses, such as medical bills. For example, a person may be injured and unable to work. In addition to income loss, they may incur additional expenses because of substantial hospital, medical, or surgical bills. Or a family head may have a dependent who sustains a serious accident or illness that requires a substantial sum of money. Unless the worker has adequate savings, health insurance, or other sources of funds on which to draw, economic insecurity is aggravated because of the additional expense.

Uncertainty of Income

Economic insecurity may also be present if the worker, although employed, is uncertain of the future continuation of present income. For example, a highly paid engineer may become fearful and apprehensive because the firm did not receive an expected government contract. In such a case, the worker experiences a form of economic insecurity because of the uncertainty of future income.

However, one must understand that the relative certainty of future income by itself does not contribute to economic security if the income a person actually receives is insufficient to satisfy their basic needs and wants. A person may be relatively certain that their present income will continue in the future, but they may not experience economic security if the income is insufficient for satisfying basic needs and wants.

For instance, assume that an aged person with no other source of income receives a retirement benefit of $500 monthly from a public pension. Although the person is relatively certain that the income will continue for as long as they live, economic security is impossible because the income is insufficient. In short, it is not merely the relative certainty of future income that makes a person economically secure; it is the continuous receipt of an adequate income that enables the person to enjoy economic security.

Causes of Economic Insecurity

Numerous elements cause economic insecurity. The major causes include:

- premature death of the family head
- old age
- poor health
- unemployment
- substandard wage
- inflation
- natural disasters
- personal factors.

Premature Death of the Family Head

This element can be defined as the death of a family head with unfulfilled financial obligations, such as dependents to support, a mortgage to be paid, or children to educate. Premature death causes economic insecurity because of the loss of income to the dependents. If the family lacks additional sources of income or has insufficient financial assets to replace the lost income, financial hardship may result.

It must be pointed out here that premature death can create economic insecurity only if the deceased has dependents and dies with unsatisfied financial obligations. Thus, the death of a child aged 7 is not regarded as being premature in the economic sense.

Old Age

Old age is another important cause of economic insecurity. An estimated 31.9 million people, or 12.4 percent of the population, were age 65 or older in 1990. The actual number of aged persons is expected to increase sharply to 60.9 million in 2025, or about 20 percent of the population. Many of them will experience considerable economic insecurity during their old age.

Old age can cause economic insecurity because of the loss of earned income. When older workers retire, they lose their work earnings. Unless they have accumulated sufficient financial assets on which to draw or have access to other sources of income, such as public or private pensions, they will be exposed to economic insecurity.

Finally, some aged persons experience economic insecurity because of early retirements and inadequate income, an erosion of real income because of inflation, high property taxes, and exploitation.

Poor Health

Poor health is another important cause of economic insecurity. A serious illness or injury can create serious financial problems for the disabled person. Two major problems are present if the sickness or injury is severe and prolonged. The high cost of medical bills and the extraordinary cost of hospital stays must be paid. Although most Americans have some type of health insurance to cover their medical bills, a large number of people are uninsured at some time during the year.

Unemployment

Unemployment can also cause economic insecurity. This condition can result from a deficiency in aggregate demand, technological and structural changes in the economy, seasonal factors, or frictions in the labor market. Regardless of the cause, economic insecurity can be present in at least four ways. First, unemployment causes the worker to lose their earned income. Unless there is a replacement income from other sources (such as unemployment insurance) or past savings on which to draw, the worker will be economically insecure. Second, because of economic reasons, the worker may work only part-time. Since work earnings are reduced, the income may be inadequate to maintain the worker and their family. Third, because of seasonal elements, the worker may be unemployed for a certain period each year. Finally, unemployment causes economic insecurity because of the uncertainty of income.

Substandard Wage

A substandard wage is any wage that is below some specified minimum necessary for workers to support themselves and their families. A careful distinction must be made between a substandard wage and an insufficient income. The former refers to a wage rate so low that the workers cannot adequately support themselves and their families if they are paid at that rate for any extended period. The federal minimum wage, formerly intended to meet all necessary living expenses, is currently an example of a substandard wage.

If a family head with several dependents is paid only the federal minimum wage for any extended period, the worker and their family will be living in poverty. On the other hand, insufficient income means that the absolute amount of income received during some period is inadequate in terms of the worker's basic needs and wants. The substandard wage is the cause, and insufficient income is the result. If the worker is paid a substandard wage for any extended period, they will be living in chronic poverty.

It should be pointed out that insufficient income may be attributable to causes other than a substandard wage, for example, seasonal unemployment, poor health, or mental or physical defects that render a person incapable of employment. In all cases, the insufficient income leads to economic insecurity.

Inflation

If consumer prices increase at a faster rate than money income, real income declines, and economic security is threatened. A rapid increase in prices tends to hurt those workers whose wages lag behind the increase in prices. In particular, the working poor are severely hurt by rapid inflation, at least in the short run, because the wages they receive may increase less rapidly than consumer prices. Since food and energy costs may rise substantially, the working poor are then confronted with the unpleasant dilemma of spending relatively more of their limited incomes on food and utilities simply to survive. Considerable economic insecurity is the result.

Natural Disasters

Floods, hurricanes, tornadoes, earthquakes, forest fires, and other violent natural disasters can result in a loss of millions in property damage, as well as numerous deaths. Natural disasters cause financial insecurity because of the considerable loss of human lives and the resulting loss of income to the stricken families. In addition, many property damage losses are either uninsured or underinsured, causing substantial additional expenses.

Personal Factors

In some cases, people are primarily responsible for their own economic insecurity. Some have little motivation to improve themselves economically. Others are spendthrifts and are indifferent to a personal savings program of investments and private life insurance. Finally, some people lack the foresight and wisdom to provide for potential risks that could cause economic insecurity.

Essentially, social insurance is considered to be a major solution for meeting and alleviating the problems of economic insecurity.

At this point, careful note should be made of the use of the term “Social Security.”

“Social Security” and the Social Security Program

It is important that you do not interpret the reference to Social Security programs as meaning the Social Security Program. The Social Security Program encompasses many social programs in and of itself. Social Security programs are part of the overall economic security programs in the United States, but are narrower in scope. There are several chief characteristics of the Social Security Programs.

First, Social Security programs are established by government statute. Second, the programs generally provide individuals with cash payments that replace at least part of the income loss from old age, disability, death, sickness, maternity, unemployment, and occupational injuries. Family allowances and statutory programs that provide medical care are also considered Social Security programs.

Social Security programs can be distinguished by the major approaches used to provide cash payments and services. These approaches include:

- social insurance
- social assistance
- universal or demogrant programs
- public provident funds.

Social Insurance

Social insurance is a part of Social Security. Social insurance programs are not financed primarily out of the general revenues of government, but are financed entirely or in large part by special contributions from employers, employees, or both.

These contributions are usually earmarked for special funds that are kept separate from ordinary government accounts; the benefits, in turn, are paid from these funds. In addition, the right to receive benefits is ordinarily either derived from or linked to the recipient’s past contributions or coverage under the program, and the benefits and contributions generally vary among the beneficiaries, according to their prior earnings.

Most social insurance programs are compulsory; certain categories of workers and employers are required by law to pay contributions and participate in the programs. Finally, qualifying conditions and benefit rights are usually prescribed exactly in the statutes, leaving little room for administrative discretion in the award of benefits.

Definition of Social Insurance

Because of conceptual and practical difficulties, the task of defining social insurance is a complicated, if not impossible, task. Besides, after defining it, there is still the problem of determining those programs that can be called social insurance and excluding those that fall outside the definition. After careful study and discussion, the Committee on Social Insurance Terminology of the American Risk Insurance Association has defined social insurance as follows:

A device for the pooling of risks by their transfer to an organization, usually governmental, that is required by law to provide pecuniary or service benefits to or on behalf of covered occurrences of certain pre-designated losses under all of the following conditions:

Except during a transition period following its introduction, eligibility for benefits is derived, in fact or effect, from contributions having been made to the program by or in respect of the claimant or the person as to whom the claimant is a dependent; there is no requirement that the individual demonstrate inadequate financial resources, although a dependency status may need to be established.

The method for determining the benefits is prescribed by law.

The benefits for any individual are not usually directly related to contributions made by or in respect of them, but instead usually redistribute income so as to favor certain groups, such as those with low former wages or a large number of dependents.

There is a definite plan for financing the benefits that are designated to be adequate in terms of long-range considerations. Persons, their employers, or both.

The plan is administered or at least supervised by the government.

The plan is not established by the government solely for its present or former employees.

Social insurance is similar to private insurance in many respects. However, it does possess some unique characteristics normally not found in private insurance. The failure to recognize these similarities and differences has led to much error and confusion regarding the desirability of economic security programs.

The Committee on Social Insurance Terminology considers the following programs to be social insurance because they fall under the preceding definition:

1. Old-Age Survivors Disability and Health Insurance.
2. Unemployment insurance.
3. Workers' compensation.
4. Compulsory Temporary Disability Insurance.
5. Railroad Retirement System.

Railroad Unemployment and Temporary Disability Insurance.

At the same time, the programs listed below are not social insurance because they do not satisfy that definition:

Civil Service Retirement System. This is not social insurance since the plan was established by the government solely for its employees.

National Service Life Insurance. This program is not compulsory; in addition, it was established by the government solely for its present or former employees.

Federal Corp. Insurance. This program is not compulsory.

Public assistance. The individual must demonstrate that they have inadequate financial resources; a formal means test must be satisfied; and finally, the cost is not borne directly by employers and their employees.

Veterans' benefits. The plan is financed entirely out of general revenues; it was established by the government solely for its former employees, and some benefits require that the applicant's income be below a specified level.

Coverage is compulsory by law in virtually all instances.

Social Assistance

Social assistance is another approach to Social Security. Social assistance programs (often referred to in different countries as public assistance, national assistance, old age assistance, unemployment assistance, social pensions, etc.) provide cash payments and other benefits to individuals. These programs have several common features:

- The benefits are usually confined to low-income or poor recipients.
- The benefits are normally granted only after an investigation of the recipient's financial resources and needs.
- The benefit amount is commonly adjusted to the recipient's financial resources and needs.
- The benefits are usually financed entirely out of the general revenues of the government.

In the United States, public assistance or welfare is used to provide cash income and other benefits to poor people whose other financial resources are small or nonexistent, or for those with special needs.

Universal or Demogrant Programs

These are programs that provide flat cash benefits to citizens or residents, without regard to the recipient's income, employment, or wealth. The benefits are usually financed out of general revenues and are applied universally to persons who are residents for a specified number of years. Demogrants include old-age pensions to persons over a certain age; pensions to surviving spouses, disabled workers, and orphans; and family allowances to families with a specified number of children. Most Social Security programs that have universal pensions also have a second-tier program that is earnings-related.

Examples of universal or demogrant programs include flat pensions to people age 65 and over in Canada and family allowances to families with two or more children in France.

Public Provident Funds

Public provident funds typically are compulsory savings programs in which contributions are regularly withheld from the earnings of employees and are matched by the contributions of employers. These funds are usually found in developing countries. The funds accrue interest and are later repaid to employees at retirement or upon the occurrence of certain events, such as a pension to surviving dependents.

SECTION II — WHAT IS WORKERS' COMPENSATION?

Workers' compensation laws provide cash benefits, medical care, and rehabilitation services to workers who are disabled from work-related accidents or occupational disease, and death benefits to the survivors of workers killed on the job. Workers' compensation laws exist in all states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands. Two federal workers' compensation laws are also in operation. The various workers' compensation laws differ widely with respect to coverage, adequacy of benefits, rehabilitation services, administration, and other provisions.

In this text, we analyze the various state workers' compensation laws, considering in particular the following areas:

1. development of state workers' compensation laws,
2. objectives and theory underlying them,
3. statutory provisions,
4. problems and issues in workers' compensation laws -
5. recommendations for improvement.

Development

Workers' compensation was the first form of social insurance to develop in the United States. Its development can be conveniently analyzed in three stages:

- The common law of industrial accidents.
- The enactment of employer liability laws.
- The emergence of workers' compensation legislation. These concepts are discussed below.

Common Law of Industrial Accidents

The common law of industrial accidents was the first stage in the development of workers' compensation in the United States; its application dates back to 1837. Under the common law, workers injured on the job had to sue their employers and prove negligence before they could collect damages. The employer was permitted to use three common law defenses to block the worker's suit:

Under the contributory negligence doctrine, injured workers could not collect damages if they contributed in any way to their injuries.

Under the fellow servant doctrine, an injured worker could not collect if the injury resulted from the negligence of a fellow worker.

Under the assumption of risk doctrine, the injured worker could not collect if they had advance knowledge of the dangers inherent in a particular occupation.

As a result of these harsh defenses, relatively few disabled workers collected damages for their injuries. Lawsuits were expensive, and the damage awards were small. Furthermore, legal fees had to be paid out of these small awards, and there was considerable uncertainty regarding the outcome of the lawsuit.

The disabled worker had two major problems to solve: the loss of income from the disabling accident and the payment of medical expenses. Under the common law, these problems were largely unsolved, resulting in great economic insecurity and financial hardship for the disabled workers.

The Enactment of Employer Liability Laws

Because of the deficiencies in the common law, most states enacted employer liability laws between 1885 and 1910. These laws lessened the severity of the common law defenses and improved the legal position of the injured workers. For example:

Three states substituted the less severe doctrine of comparative negligence for contributory negligence.

- The fellow servant rule and assumption-of-negative risk doctrine were modified.
- Employers and employees were denied the right to sign contracts that would relieve employers of legal liability for industrial accidents.
- Surviving dependents were allowed to sue in death cases.

Despite some improvements, however, the fundamental problems experienced by disabled workers still remained. The injured employee still had to sue the employer and prove negligence, and there were still long delays in securing court action. Lawsuits remained costly, and the legal outcome was uncertain. Also, the worker still had problems with maintaining income during disability and payment of medical expenses.

Emergence of Workers' Compensation

The Industrial Revolution, which changed the United States from an agricultural to an industrial economy, caused a great increase in the number of workers who were killed or disabled in job-related accidents. Because of limitations on both the common law and the employer liability statutes, the states began to consider workers' compensation legislation as a solution to the growing problem of work-related accidents.

Workers' compensation was slower to develop in the United States than it was abroad. Workers' compensation laws existed in Europe in the 1880s, and by 1903, most European countries had enacted some type of legislation. In 1902, Maryland passed a law, but it was limited in application and was subsequently declared unconstitutional. The stimulus for the enactment of state workers' compensation laws started in 1908, when the federal government passed a law covering certain federal employees, and by 1911, 10 states had passed workers' compensation laws. By 1920, all but six states had enacted such laws. Workers' compensation programs exist in all states today.

Workers' compensation is based on the fundamental principle of liability without fault.

The employer is held absolutely liable for the occupational injuries suffered by the workers, regardless of who is at fault. The injured worker is compensated for their injuries according to a schedule of benefits established by law and does not have to sue the employer to collect benefits. The laws provide for the prompt payment of benefits to injured workers, regardless of fault, with a minimum of legal formality.

Objectives

There are five basic objectives in workers' compensation laws:

1. Broad coverage of employees for occupational injury and disease.
2. Substantial protection against occupational injury and disease, and loss of income.
3. Sufficient medical care and rehabilitation services.
4. Encouragement of safety.
5. An effective delivery system for benefits and services.

Broad Coverage

Broad coverage means that the laws should cover most employees for all work-related injuries and occupational diseases. Reasons why certain groups should be excluded have been presented, but the arguments have not withstood careful analysis. Arguments have been presented citing that some firms should be excluded because they are small, have poor safety records, or are reluctant to bear the cost of workers' compensation benefits.

In response, states have extended their workers' compensation laws to cover most firms, without undue financial distress. And, if the cost of covering certain excluded groups is high, then the disabled workers and society in general are bearing the costs of occupational injuries to these groups in the form of poverty or welfare programs. These costs should be charged to the firms and not to society. The states answered many other arguments against the "broad coverage" aspects of the program merely by establishing mandatory workers' compensation laws to protect workers from possible poverty and destitution.

Substantial Protection Against the Loss of Income

The second basic objective of workers' compensation laws is that the benefits should replace a substantial proportion of the disabled worker's lost earnings. The measure of a worker's economic loss is the lifetime reduction in remuneration because of occupational injury or disease.

Gross remuneration consists of basic wages and salaries, irregular wage payments, pay for leave time, and employer contributions for fringe benefits and Social Security benefits. The measure of loss is the difference in net remuneration before and after the work-related disability. This net remuneration reflects taxes, job-related expenses, fringe benefits that lapse, and uncompensated expenses that result from the disability.

The view that workers' compensation should restore a large proportion of the disabled worker's lost remuneration can be justified by two major considerations. First, workers' compensation is social insurance, not public assistance. Public assistance programs provide benefits based on a person's demonstrated need.

Workers' compensation benefits, however, should be closely related to the workers' loss of present and future income, and so should be considerably higher than a subsistence level of income.

Second, in exchange for the workers' compensation benefits, disabled workers renounce their right to seek redress for economic damages and pain and suffering under the common law. Other social insurance programs, including Social Security and unemployment insurance, do not require the surrender of a valuable legal right in exchange for benefits.

Under the program, both minimum and maximum weekly cash payments must be established. A minimum benefit is one necessary to keep the disabled worker off welfare; a maximum amount must be set because highly paid workers are in a position to provide for their own disability income insurance if the workers' compensation benefits are inadequate. A maximum limit is also necessary to constrain labor supply disincentives to work.

Sufficient Medical Care and Rehabilitation Services

Workers' compensation also has the objective of providing sufficient medical care and rehabilitation services to injured workers. The laws require the employer to pay medical, hospital, and surgical expenses, and other medical bills relating to the disability.

Vocational counseling, guidance, retraining, and other rehabilitation services are also provided to restore the injured worker to gainful employment. Disabled workers who can be returned to productive jobs can experience a feeling of well-being and worth as a result, and adequate and prompt rehabilitation services can reduce workers' compensation costs.

Encouragement of Safety

Workers' compensation programs also encourage safety and the development of sound safety programs. Experience rating is used to encourage firms to be safety-conscious and to make a determined effort to reduce industrial accidents, since firms with superior accident records pay relatively lower workers' compensation premiums.

For safety-conscious firms, the end result is often an improvement in the competitive position. For instance, firms and industries with superior safety records generally are not penalized for others' lack of safety standards and initiatives.

The laws allocate the costs of industrial accidents and occupational disease among those firms and industries responsible for them, so a firm or industry with a poor safety record may have to increase its prices, thereby losing some customers to other firms with lower rates of injury and disease. An individual firm with a poor safety record will generally have higher costs and lower profits, which weaken its competitive position.

An Effective Delivery System

Finally, the workers' compensation programs have the objective of providing an effective delivery system, by which the benefits and services are provided comprehensively and efficiently.

Comprehensive performance means that workers' compensation personnel should exist in sufficient numbers and quality to conduct the objectives of the program. High-quality performance is expected of employers, physicians, state courts, and workers' compensation insurers and agencies.

Efficient performance means that the services necessary to restore an injured worker are provided promptly, simply, and economically. Efficiency can be judged by comparing the workers' compensation program with similar activities outside the system.

Comparison with Similar Programs

A multitude of errors in thinking surround our social insurance programs. This is due partly because of a misunderstanding of the principles, nature, and objectives of social insurance. Comparisons with private insurance are often improperly made. It is important, therefore, to analyze the basic principles and characteristics of social insurance programs so that these programs can be viewed in their proper perspective.

Social Security

The federal Social Security system began in 1935 in an effort to provide limited retirement or death benefits for workers in commerce and industry. Since 1935, the program has greatly expanded, and benefits have increased dramatically. Significant changes in the Social Security system occurred as follows:

- In 1954, coverage became almost universal.
- In 1956, disability insurance benefits were added. In 1958, disability eligibility was liberalized, and benefits were added for dependents of disability insurance recipients.
- In 1961, early but reduced retirement was permitted for men at age 62.
- In 1965, Medicare benefits were added.
- In 1972, automatic cost-of-living adjustments (COLA) were added to the benefit system.
- In 1977, substantial increases in tax rates were enacted to cover projected long-term deficits.
- In 1981, short-term deficits were financed by interfund borrowing.
- Amendments in 1983 resulted in the following changes:
- Certain Social Security benefits were taxed for the first time.
- The normal retirement age was to be gradually changed from 65 to 67.
- Mandatory coverage was established for employees of nonprofit organizations.
- Some federal workers would be covered by Social Security rather than by civil service.
- Deferred compensation plan taxation was established for Social Security purposes.
- States were prohibited from terminating coverage of state and local government employees.
- Cost-of-living adjustment computation methods were altered.
- Several gender-based distinctions previously made by the Social Security laws were eliminated.

The Disability Reform Act of 1984 changed the standard of review for terminating disability benefits and, among other changes, provided for the evaluation of pain. Technical amendments were passed in 1986 and 1987. Catastrophic health care coverage and financing were enacted under the Medicare Catastrophic Coverage Act of 1988; however, Congress voted to repeal this act in 1989.

Today, the Social Security system contains the following benefit programs:

1. Old-Age Survivors Disability Insurance (OASDI).
2. Medicare.
3. Supplemental Security Income (SSI).

For the most part, Social Security benefits are financed by taxes or contributions collected from employers, employees, and self-employed persons who work in employment covered by Social Security. The Federal Insurance Contributions Act (FICA), which falls within the Internal Revenue Code, governs taxation and collection.

Eligibility for retirement and survivor benefits depends on the insured status of an employee.

Generally, an employee's insured status is established by the number of quarters of coverage that have been earned in work covered by Social Security. A worker and family can become fully insured with as little as 31 quarters (eight years) of work. The requisite age and quarters of coverage can vary.

If a worker is currently insured, benefits can be paid to survivors upon the worker's death; six quarters of coverage in the 13 quarters preceding death gives rise to this currently insured status. OASDI benefits are conditional upon the attainment of age or death. Full OASDI benefits are payable at age 65; reduced benefits are available at 62. Other OASDI benefits have age eligibility variations. OASDI benefits are in the form of monthly benefit payments.

In general, the test for disability benefit eligibility employs the same insured status concept used by Old-Age Survivors Insurance. Disability eligibility requires that an employee be both: 1) fully insured under OASI and 2) disability insured.

The disability insured requirement is met if a worker has 20 quarters of coverage in the 40 quarters immediately preceding disability. A waiting period of five months exists before these benefits can be paid.

At age 65, disability benefits cease, and regular full retirement benefits are paid. In making eligibility determinations, disability is generally defined as the inability to engage in gainful activity by reason of any medically determinable physical or mental impairment that can be expected to last at least 12 continuous months or to result in death. Social Security disability benefits are generally offset by any other disability benefits.

Certain disabled and aged persons are entitled to the benefits of a national health insurance program (Medicare). Most people over 65 are eligible automatically; if one is not eligible, coverage can be purchased for an annual premium.

There are three basic Medicare programs: 1) part A, Hospital Insurance (HI), which is fundamentally financed through special payroll taxes similar to FICA taxes, which are held in the Hospital Insurance Trust Fund; 2) part B, Supplementary Medical Insurance (SMI), which is fundamentally financed through individual medical premiums and general revenues of the United States, which are held in the Supplementary Medical Insurance Trust Fund and 3) Medicare+Choice, which became effective in 1998. Both Part A and Part B benefit programs contain cost-sharing measures, usually in the form of coinsurance and deductibles.

The Department of Health and Human Services administers both programs. Part A payments are generally tied to benefit periods. If a patient has not been hospitalized for 60 consecutive days, a benefit period is available; there are no limits on the number of benefit periods that patients can have during their lifetime.

The Supplemental Security Income (SSI) program provides financial assistance to U.S. citizens and lawfully admitted aliens who meet income and resource criteria. They must be aged, blind, or disabled. The SSI program provides a floor of income for these persons, and it is financed by general tax revenues. SSI benefits are paid monthly to persons who are aged 65 or older, blind, or disabled. These persons must be U.S. citizens or lawful residents of the 50 states, the District of Columbia, or the Northern Mariana Islands.

Fundamental concepts include:

- basic principles and characteristics of OASDI
- desirability of a voluntary OASDI program
- whether the OASDI program can properly be called insurance
- comparison of social insurance with private insurance
- comparison of social insurance with public assistance
- economic objectives of social insurance.

With few exceptions, the OASDI program coverage is compulsory. This principle has been consistently followed since the passage of the original Social Security Act in 1935. A compulsory program makes it easier to protect the population against certain social risks, such as premature death of the family head, insufficient income during retirement, or long-term disability. By a compulsory program, a basic floor of income protection for the masses can be more easily achieved, and both healthy and unhealthy people can be covered.

The OASDI program provides only a minimum floor of income protection against the various risks covered. Traditional philosophy in the United States says that the individual is primarily responsible for their own economic security, and if government assistance is necessary, only a minimum benefit should be paid. People are expected to supplement government economic security programs with their own programs of savings, investments, and insurance.

The concept of a minimum floor of income is difficult to define, and some disagreement exists concerning the minimum and maximum benefits that should be paid. Generally, there are three views regarding the minimum floor.

First, one view is that the minimum should be so low as to be virtually nonexistent. Second, the other extreme says that it should be high enough to provide a comfortable standard of living by itself, with no consideration given to other economic security programs provided by private or group methods (private insurance, group insurance, private pensions).

Third, a middle view is that the minimum income should, in combination with other income and financial assets, be sufficient to maintain a reasonable standard of living for the vast majority of people. Any residual group whose basic needs are then still unmet would be provided for by supplementary public assistance.

OASDI emphasizes the payment of benefits based on social adequacy rather than individual equity.

“Social adequacy” means that the benefits paid provide a certain standard of living to all contributors.

“Individual equity” means that contributors receive benefits directly related to their contributions; in technical terms, the actuarial value of the benefits is closely related to the actuarial value of the contributions. The OASDI program provides benefits on a basis falling between complete social adequacy and complete individual equity, with heavy emphasis on the former.

The purpose of the social adequacy principle is to provide a minimum floor of income to all groups. If certain groups received OASDI benefits actuarially equal to the value of their contributions (individual equity principle), the benefits paid would be so small for some groups (for instance, lower-income groups) that the objective of providing a minimum floor of income to everyone would not be achieved.

Although the OASDI program and other social insurance programs emphasize social adequacy, private insurance stresses the individual equity principle. Losses are pooled, and people with roughly the same loss-producing characteristics are grouped into the same class and pay roughly equal premiums. Private insurance is voluntary and may be built on equity between different classes of insureds.

It is considered inequitable to have one relatively homogeneous group of insureds pay a large part of the loss costs for another group whose loss-producing characteristics are substantially different. Furthermore, once people in the first category become aware that they could save money by being treated as independent, financially self-contained units, they would tend to drop their insurance.

However, OASDI and other social insurance programs are different in character and have different functions. Since social insurance programs are generally compulsory, they are aimed at providing society with some protection against major social risks. The benefit structure is designed to provide society with a minimum floor of income so that people do not become wards of society. It is only after this objective is achieved that any remaining funds can be considered available for providing additional benefits based on individual equity.

In the OASDI program and other social insurance programs, the benefits are prescribed by law, with the administration or supervision of the plan performed by the government. In all social insurance programs, the benefits or benefit formulas are established by statute, as are the eligibility requirements. Although the OASDI program is administered by the federal government, the level of administration in other social programs may be state or local.

The claims procedure for most Social Security benefits is initiated on special forms provided by the Social Security Administration. These claim forms are usually filed with a local Social Security office, which makes an initial determination of eligibility. If there is a dispute, the claimant or the claimant's representative must request a reconsideration of the initial decision. A claimant who is dissatisfied with a reconsideration decision is entitled to a hearing before an administrative law judge.

This judge's decision becomes final unless an Appeals Council review is requested within 60 days of receipt by the claimant, or unless the Appeals Council decides to review the decision on its own motion. Denials of review or decisions of the Appeals Council can be appealed within 60 days to the U.S. District Courts. Attorney fees are permitted for the representation of claimants. Furthermore, in some cases, the claimant may be entitled to an additional award of attorney fees under the Equal Access to Justice Act.

Temporary Disability Insurance Program

Workers' compensation statutes ordinarily provide four classifications of disability. These classifications are determined by the severity or extent of the disability, with the disability characterized as either partial or total. Additionally, disabilities are affected by their duration and are characterized as either permanent or temporary. The four common disability classifications are: temporary partial, temporary total, permanent partial, and permanent total. These classifications, in conjunction with the employee's average wages and appropriate statutory formulas, provide the basis for disability benefit computation.

Temporary Partial

A temporary partial disability is present when an employee who has been injured on the job is no longer able to perform that job, but for the period of disability can engage in some kind of gainful employment. Temporary partial disability compensation is designed to pay an injured worker for lost wages, and thus, wage loss theory is generally employed in making awards. This classification promotes the prompt return of an injured employee to the workforce. Examples of this type of injury include sprains, minor fractures, contusions, and lacerations.

The critical factor in determining the temporary partial classification may be the impairment of the employee's earning capacity.

Temporary Total

The condition of temporary total disability exists when an employee is unable to work at all for a temporary, but undetermined, amount of time. One may be totally disabled, even though not completely helpless or wholly disabled. Examples of injuries that can result in temporary total disability are serious illnesses, heat exhaustion, and disabling back injuries. Temporary total disability is designed to provide compensation to an injured worker for the economic losses incurred during a recuperative period.

Permanent Partial

A permanent partial disability may be found when a permanent and irreparable injury has occurred to an employee, i.e., one that probably will continue for an indefinite period with no present indication of recovery. For example, one who loses a foot on the job will experience a period of temporary total disability during hospitalization and recuperation. At the point in time when maximum medical improvement has been attained, the disability should be classified as permanent partial. The employee is now able to perform some gainful work.

The purpose of permanent partial disability is to provide compensation for the employee's reduced earning capacity, even though this is often accomplished through the use of a medical loss schedule. It should be noted that the majority view is that if a scheduled injury produces additional disability to other parts of the body, the employee will be able to recover an amount above that provided in the schedule; for example, the loss of a foot could produce traumatic neurosis.

Permanent Total

The condition of permanent total disability exists when an employment-related injury renders an employee permanently and indefinitely unable to perform any gainful work. An employee need not be entirely helpless or completely incapacitated in a medical sense. The so-called "odd-lot" doctrine permits the finding of a permanent total disability for workers who are not completely incapacitated but are handicapped to such an extent that they cannot become regularly employed in a capacity in which they are skilled; the worker is said to have been left in the position of an "odd-lot" in the labor market.

One may receive a permanent total disability based on a scheduled loss; for example, loss of sight in both eyes can be a scheduled loss that requires compensation as a permanent total disability. It is difficult to generalize about permanent total disabilities, but the following factors are generally relevant to such determinations: age, experience, skills and training, education, nature and extent of injury, employment history, and nature of employment at the time of injury.

Unemployment Insurance Program

In 1935, an unemployment insurance system was established to provide economic security for workers during periods of temporary unemployment. The original system was created by Title IX of the Social Security Act of 1935. In 1939, the tax provisions of Title IX became the Federal Unemployment Tax Act under the Internal Revenue Code. Today, the Social Security Act, the Federal Unemployment Tax Act, and numerous amendments to these acts provide the statutory basis for federal unemployment compensation programs in the United States. For the most part, constitutional challenges to the system have been unsuccessful.

The principal federal statutes comprising the basis of the unemployment insurance program are:

- The Federal Unemployment Tax Act.
- The Social Security Act.
- Titles III, IX, and XII.
- The Wagner-Peyser Act.
- The Social Security Amendments of 1960.

- The Manpower Development and Training Act of 1962.
- The Federal State Extended Unemployment Compensation Act of 1970.
- The Disaster Relief Act of 1970.
- The Emergency Unemployment Compensation Act of 1971.
- The Disaster Relief Act of 1974.
- The Emergency Unemployment Act of 1974, as amended.
- The Emergency Compensation and Special Unemployment Assistance Act of 1975.
- The Unemployment Compensation Act Amendments of 1976.
- The Emergency Unemployment Act of 1977.
- The Omnibus Reconciliation Act of 1980.
- The Omnibus Budget Reconciliation Act of 1981.
- The Tax Equity and Fiscal Responsibility Act of 1982.
- The Social Security Amendments of 1983.

In addition to the foregoing, each state, the District of Columbia, Puerto Rico, and the Virgin Islands have separate unemployment compensation laws.

The unemployment insurance program relies on cooperative federal-state programs. Federal laws provide general guidelines, standards, and requirements, with administration left to the states under their particular unemployment legislation. The unemployment compensation system is generally funded by unemployment insurance taxes or contributions imposed upon employers.

The federal taxes are generally applied to the costs of administration, while the state taxes provide trust funds for the payment of benefits. Federal taxes are paid into a Federal Unemployment Trust Fund, from which administrative costs and the federal share of extended benefits are paid.

The fund is also used to establish a Federal Unemployment Account from which the states can borrow if their state trust funds become depleted. Unemployment taxes should not be confused with the separate Social Security taxes imposed by the federal government, nor with the separate disability benefits taxes imposed by some states. Unemployment benefits are taxable as ordinary income.

Federal Unemployment Insurance Programs

The principal vehicle for providing weekly unemployment benefits is referred to as the regular state program. Subject to federal guidelines, the states determine:

- qualifying requirements,
- amounts of benefits,
- duration, and
- grounds for disqualification.

State unemployment laws vary, and qualification requires a demonstration of employment by an employer subject to the unemployment tax of a particular jurisdiction, and employment during a base period—a recent 12-month period.

Generally, one must have been employed in more than one quarter.

Payments usually take the form of weekly benefits calculated on the basis of a particular jurisdiction's formula. Commonly, an employee's average weekly wage provides the basis for the weekly benefit amount, and this average amount is determined by dividing one's high quarter wages by the 13 weeks in a quarter; one-half of the result is the weekly benefit amount paid to the worker. There is usually a one-week waiting period prior to the initial payment of benefits.

The duration of unemployment varies with the particular jurisdiction. The vast majority of jurisdictions determine duration on the basis of the length of employment or the amount earned. Usually, the longer the length or the greater the amount, the more weeks of benefits one can receive.

Workers can be denied unemployment compensation if certain grounds for disqualification exist. Policy dictates payment only to those employees who have lost their jobs through no fault of their own. In all jurisdictions, an employee is disqualified from benefits if the worker voluntarily quits employment without good cause or is discharged for employment-related misconduct.

Additionally, disqualification can occur at any time if a claimant or benefit recipient refuses to accept suitable employment without good cause. For benefits to continue, a claimant must:

1. Register for employment with the jurisdiction's employment service.
2. Be able to work.
3. Be available for work.
4. Seek work on one's own.

Claims examiners make initial findings of fact that lead to a grant or a denial of unemployment compensation benefits.

The appellate rights of a dissatisfied claimant are generally guaranteed by Title III of the Social Security Act, Section 303(a), which requires administration by the states in a manner reasonably calculated to insure full payment of unemployment benefits when due and an opportunity for a fair hearing before an impartial tribunal for all individuals whose claims for unemployment are denied.

An employer's unemployment experience rating affects the amounts that an employer is required to contribute.

Certain amendments have provided extended, supplemental, or special unemployment benefits, thus increasing unemployment compensation for many unemployed persons in the United States. For example, individuals who have exhausted their regular program entitlements can receive further compensation through the Federal-State Extended Benefits Program.

Under this program, the costs are shared equally by the federal and state governments. The Omnibus Budget Reconciliation Act of 1981 repealed the national "on" and "off" triggering indicators that automatically regulated the extended benefits program.

The Federal Supplemental Compensation Act of 1982 made additional unemployment compensation benefits available in states experiencing periods of higher unemployment. These benefits are funded out of general federal revenues. The Social Security Amendments of 1983 extended the Federal Supplemental Compensation program.

SECTION III — WORKERS' COMPENSATION LAWS

The U.S. Constitution prohibits states from enacting laws that impair contract obligations. As a result of this general prohibition and the parallel provisions sometimes found within state constitutions, some workers' compensation acts were held at one time to violate these provisions.

The general view is to the effect that even if a workers' compensation act impairs an existing contract obligation between an employer and employee, the impairment may nevertheless be valid because a proper exercise of the police power has occurred. The health, safety, and welfare of the people are of overriding importance.

Many of the original workers' compensation acts were said to be elective in order to avoid the constitutional difficulties imposed by the impairment of contract clause. The majority of states have enacted constitutional amendments that eliminate the constitutional difficulties originally imposed in this area. Virtually all states today have compulsory coverage.

This has generally been accomplished by state constitutional amendments authorizing workers' compensation statutes. These state amendments grant the necessary legal power for the enactment of workers' compensation laws. The grants include the power to enact all reasonable and proper provisions necessary to enforce the law and to fulfill the objectives of the constitutional provisions. Needless to say, the legislation cannot exceed whatever limitations exist in the constitutional provision.

Regardless of whether a workers' compensation act is compulsory or elective, it generally affords the exclusive remedy for employees or dependents against employers for personal injuries, diseases, or deaths arising out of and in the course of employment. The exclusivity provision of workers' compensation acts is the keystone of all such legislation. The employee or dependents recover without regard to fault, and the employer is spared the possibility of large tort verdicts.

State Workers' Compensation Laws

Three states have elective laws, whereby the employer can either elect or reject the state plan. These states are: New Jersey, South Carolina, and Texas. Under elective plans, if the employer rejects the act and the injured worker sues for damages based on the employer's negligence, the employer is deprived of the three common law defenses of contributory negligence, the fellow servant rule, and assumption of risk.

Although most firms elect workers' compensation coverage, some do not, so some disabled employees are unable to collect benefits unless they sue for damages. Elective laws also permit firms' employees to reject coverage, but they seldom do. Under most elective laws, it is presumed that both the employer and the employees elect coverage, unless a specific notice of rejection is filed prior to a loss.

Employers can comply with the law by purchasing a workers' compensation policy, by self-insuring, or by obtaining protection from a monopoly or competitive state fund.

Most firms purchase a policy from a private insurer. The policy guarantees payment of the benefits that the employer is legally obligated to pay to the disabled workers. Self-insurance is permitted in 47 states. In addition, 28 states permit group self-insurance for smaller employers who collectively pool their workers' compensation loss exposures. However, the laws require firms to meet certain requirements before they can self-insure.

Monopoly State Funds

In eight jurisdictions, employers generally must be insured in a monopoly state fund. Monopoly state funds have been established for the following reasons:

- Workers' compensation is social insurance, and private companies should not profit from the business.
- Monopoly state funds should have reduced expenses because of economies of scale and no sales effort.
- Monopoly state funds have a greater concern for the welfare of injured workers.

Monopoly state funds exist in Nevada, North Dakota, Ohio, Washington, West Virginia, Wyoming, Puerto Rico, and the Virgin Islands.

Competitive State Funds

Thirteen states permit employers to purchase insurance from either private insurers or competitive state funds. Competitive state funds are established for the following reasons:

- The fund provides a useful standard for measuring the performance of private insurers.
- The states want to make certain that all employers can obtain the necessary protection.
- A competitive fund operates more efficiently if it faces competition from private insurers.

Competitive state funds exist in the following 13 states:

- Arizona
- California
- Colorado
- Idaho
- Maryland
- Michigan
- Minnesota
- Montana
- New York
- Oklahoma
- Oregon
- Pennsylvania
- Utah

Employers who do not meet the insurance requirements are subject to fines, imprisonment, or both. Also, some states enjoin the employers from doing business in the state until the insurance requirements are fulfilled.

Self-Insurance

Self-insurance programs are common and permitted in most states. Employers who meet certain requirements may pay their workers' compensation liabilities directly, rather than by purchasing insurance. As insurance premiums rise, this has become an attractive option for employers with the size and expertise to administer such a program. Self-insurance programs exist in all but three jurisdictions: North Dakota, Puerto Rico, and Wyoming.

State Temporary Disability Laws

These laws provide benefits for workers who are temporarily disabled by injuries or illnesses not related to their employment. Benefits may be paid by a state fund, a private insurance company, or directly by a self-insured employer. California, Hawaii, New Jersey, New York, Puerto Rico, and Rhode Island have laws providing these benefits.

Temporary disability benefits cover persons who are unable to work because of illness or injury, but who do not qualify for benefits under workers' compensation or unemployment compensation laws. Workers' compensation laws cover only injuries or illnesses that are work-related; unemployment laws require that beneficiaries be able and available to work.

New York's temporary disability law is administered in conjunction with the state workers' compensation law. Hawaii's law stands alone, and the other states and Puerto Rico administer their laws as adjuncts to their unemployment insurance laws. While temporary disability laws often share definitions and exclusions with the state unemployment law, temporary disability benefits are often specifically extended to workers not covered under the unemployment laws. Also, employers should note that Puerto Rico has a separate childbirth leave act, providing up to eight weeks of leave at 50 percent of wages; temporary disability benefits are also payable during this leave.

Employers who operate in states with these laws are required to perform certain duties in connection with the laws. Temporary disability benefits may be financed by employee contributions withheld by the employers, employer contributions, or a combination. Even in the states where the plans are financed solely by employee contributions, employers are responsible for withholding the contributions, paying them to the state government, and filing reports in connection with the withholding. Employers who fail to comply with these requirements are subject to penalties.

The state disability benefits laws vary considerably. All but Rhode Island permit employers to substitute an approved plan for the state plan.

As stated earlier in the discussion of the development of workers' compensation, the common law remedies and the statutory actions provided by the various employers' liability acts form the underlying layer of law upon which a remedy can be based when the applicable workers' compensation act fails to provide coverage. Thus, common law and statutory actions remain important. These laws and actions are also extremely important when there is third-party involvement and recovery is sought against them. Third parties are not covered by the act and are not allowed to limit their liability in the same manner as an employer.

State Requirements

Workers' compensation is a system of state laws, rather than an umbrella federal law. Therefore, requirements vary widely from state to state. It is necessary to know the following terms to be able to discuss the application of policy.

Employee Coverage and Exemptions

Coverage under the workers' compensation law is determined by the number of employees. Special rules apply about which employees are counted, and there are special rules applying to specific occupations, such as construction.

Minors

Minors are covered by the law in every state. Minors employed illegally, however, may be entitled to double or even triple compensation. Because benefit amounts are set based on the employee's average weekly wage, and minors are generally low-paid, the illegally employed minor's potential future earnings—what the worker might have earned as an adult, if not injured—may be considered in setting benefits in some states.

Exempt Employees

These are employees who are specifically exempt from the law. In some cases, there may be limits on the hours worked or wages paid in order for the exemption to be effective.

Exempt Injuries

Exempt injuries include only those incurred in activities or through actions on the workers' parts for which no compensation is payable. Many states provide for reduced benefits in certain circumstances, such as when the employee is injured as a result of intoxication or failure to obey safety rules.

Employer Coverage

Generally, any employer in the state, regardless of safety history, can secure insurance from the state fund.

State Funds

State funds are essentially state-run insurers. Some state-fund states prohibit private insurance.

Private Insurance

Most states permit private insurance. However, some state-fund states prohibit it.

Self-Insurance

As stated earlier, self-insurance is also permitted in most states.

Insurance Options

Insurance options are gaining in popularity. Included under this heading are programs ranging from those permitting employers to use PPOs or other managed care programs to provide medical benefits while controlling costs, and to programs allowing employers to replace their traditional workers' compensation insurance with some combination of life, disability, accident, health, or other insurance.

Deductibles

Deductibles have become an increasingly popular cost-savings option.

Medical Benefits Coverage

Waiting Period

This is the time after an accident, during which benefits, other than medical treatment, will not be paid. Generally, the waiting period will be excused after the injury has lasted for a certain amount of time. For example, benefits may not be paid for the first three days of disability unless the disability lasts 14 days or more.

Stress or Mental

Injuries of this type are usually mentioned in some state laws. Many of these laws provide fairly stringent limits on benefits for such injuries.

First Choice of Physician

The first choice of the physician may be given to the employee or to the employer. A number of states allow a second choice if the employee or employer is dissatisfied with the first choice.

Fee Limits

A number of states are imposing fee limits. These may take the form of actual schedules of approved fees for specified procedures or may be more general, limiting fees to "prevailing rates in the community" or to "usual and customary costs."

Benefit Amounts

Under the workers' compensation laws of the various states, benefit amounts set the wage replacement/indemnity benefits payable to injured workers and dependents of deceased workers.

Total Disability

These are the total benefits payable to workers unable to work as a result of an occupational injury or, in most states, disease. Permanent total disabilities are those that render the employee unable to engage in remunerative employment. In some states, certain injuries are considered permanently totally disabling—loss of eye(s) or limb(s)—even if the worker can perform some services after recovery. Temporary total disability benefits are paid during a period of recuperation, where the employee has expectations of regaining sufficient health to return to work.

Partial Disability

These benefits are paid to workers whose ability to earn has been impaired by an injury. However, some injuries are considered inherently disabling, and permanent partial disability benefits may be paid, regardless of earnings loss. Often, these benefits are expressed in terms of benefits to be paid for a specific number of weeks for a specific injury. For example, loss of a thumb may be compensated for 300 weeks, loss of one phalange of a finger compensated at the same rate for 100 weeks, etc. Injuries not specified in the law may be compensated in terms of the entire benefit for a part of the maximum number of weeks proportional to the degree of disability.

Temporary partial disability is the least clearly defined of the injury categories. Often, however, it is used as a stop-gap, being paid to individuals between the time of the injury and the time of maximum medical improvement, when, if the worker remains unable to perform the pre-injury job, wage loss or permanent partial disability benefits begin.

Survivor's Benefits

When an employee is killed on the job or dies as a result of an occupational injury or disease, persons dependent on that employee are entitled to compensation. A surviving spouse and minor children are compensated automatically in virtually all states. Most states also have provisions for other persons who may have been actually dependent on the worker, such as parents, grandparents, siblings, etc. Burial expenses are also payable in all states.

Workers' Compensation Insurance

Types of Claims

Medical coverage is usually provided in full, without any dollar limits on the amount paid. Medical costs now account for 40 percent of workers' compensation benefits.

Disability income benefits are payable after the disabled worker satisfies a waiting period that usually ranges from three to seven days. If the worker is still disabled after a certain number of days or weeks, most states pay benefits retroactively to the date of the injury.

The weekly benefit amount is based on a percentage of the worker's average weekly wage—typically 66 2/3 percent—and the degree of disability. Most states have minimum and maximum dollar limits on the weekly benefits. In addition, in most jurisdictions, the maximum weekly benefit is automatically adjusted each year based on changes in the state's average weekly wage. In 40 states, the maximum weekly cash benefit for temporary total disability cases now equals or exceeds 66 2/3 percent of the statewide average weekly wage; of these states, 29 now pay a maximum weekly benefit of 100 percent or more of the statewide weekly wage.

Classifications of Disability

Four classifications of disability are generally used to determine the weekly benefit amount.

Temporary Total

Most weekly disability income benefits are paid for temporary total disability. The employee is totally disabled but is expected to recover fully and return to work.

Permanent Total

Permanent total disability means that the employee is permanently and totally disabled and is unable to work in gainful employment. Most states pay lifetime benefits if the worker is permanently and totally disabled.

Temporary Partial

Temporary partial disability means that the disabled worker has returned to work but is earning less than before and still has not reached maximum recovery. The weekly benefit is a percentage of the difference in wages earned before and after the injury (typically 66 2/3 percent), up to the weekly maximum.

Permanent Partial

Permanent partial disability means that the employee has a permanent impairment but is not completely disabled. An example is an employee who loses one eye in a job-related accident.

Permanent partial disability cases are of two types: scheduled and nonscheduled (or wage-loss).

Scheduled Injuries—These are listed in the law and include the loss of an eye, arm, leg, hand, finger, or other member of the body. In most states, the amount paid for a scheduled injury is determined by multiplying a certain number of weeks (based on the bodily member involved) by the weekly disability income benefit. Also, in most states, the amount paid for a scheduled injury is in addition to the benefits paid during the healing period or while the worker is totally disabled.

Nonscheduled Injuries—These disabilities are of a more general nature and involve the loss of earning power to the body as a whole, such as a back or head injury that makes working difficult. The benefit paid for a non-scheduled injury is generally based on a wage-loss replacement percentage. The percentage is applied to the difference in earnings before and after the injury, multiplied by a certain number of weeks. In some states, nonscheduled permanent partial disability benefits are based on a percentage of a total disability case.

Death Benefits

Death benefits are also payable if the worker is killed on the job. Two types of benefits are paid. First, a burial allowance is paid, ranging from $600 to $5,370. Second, cash income payments can be paid to eligible surviving dependents. A weekly benefit based on a proportion of the deceased worker's wages (typically 66 2/3 percent) is usually paid to a surviving spouse for life or until they remarry. Upon remarriage, the widower/widow usually receives a lump-sum benefit, such as one or two years of payments. Benefits can also be paid to the children until age 16, 18, or later if the children are incapacitated. Many states, however, have amount or time limits on the maximum that can be paid.

Rehabilitation Services

Rehabilitation services are also available in all states to disabled workers to restore them to productive employment. In addition to weekly disability benefits, workers who are being rehabilitated are compensated for board, lodging, travel, books, and equipment. Training allowances are also paid in some states.

Second Injury Funds

All states have second injury funds. The purpose is to encourage employers to hire workers with disabilities. If a second-injury fund did not exist, employers would be reluctant to hire workers with disabilities because of the higher benefits that might have to be paid if a second injury occurs.

For instance, assume that a worker with a pre-existing injury is injured in a work-related accident. The second injury, when combined with the first injury, produces a disability greater than that caused by the second injury alone. Thus, the amount of workers' compensation benefits that must be paid is higher than if only the second injury had occurred. The employer pays only for the disability caused by the second injury, and the second-injury fund pays for the remainder of the benefit award.

Many employers are unaware of second-injury funds and how they operate and function. Thus, they may be reluctant to hire workers with severe disabilities because of the possible adverse effect on their workers' compensation premiums.

Workers' Compensation Financing

Workers' compensation benefits are financed by employer premiums or self-insurance payments, based on the theory that the costs of job-related accidents or disease are part of the cost of production. However, a few states also have provisions for nominal contributions by covered employees for hospital and medical benefits.

The actual workers' compensation premium paid by employers is based on numerous factors, including the size of payroll, industry, occupation of covered employees, and industrial operations performed. Smaller firms are class-rated. Class rating means all employers in the same class pay the same workers' compensation rate. Larger firms, whose annual workers' compensation premiums are at least $750, are subject to experience rating. Experience rating means the class-rated premium is adjusted upward or downward depending on the employer's loss of experience and the statistical reliability of that experience.

The purpose of experience rating is to encourage loss prevention by providing employers with a financial incentive to reduce job-related accidents or disease.

Finally, the costs incurred by the states in administering the workers' compensation laws and supervising insurance carriers, self-insurers, and the state funds are financed by legislative appropriations or by special assessments on insurance carriers and self-insurers.

Workers' Compensation Administration

Most states use a workers' compensation board or commission to administer workers' compensation claims. The law is administered either by an independent workers' compensation agency or by the same agency that administers the state's labor law. A few states use the courts to administer the claims. The court must either approve the settlement or, if the parties disagree, resolve the dispute.

To receive workers' compensation benefits, the injured worker must file a claim for benefits with the appropriate workers' compensation agency and give proper notice to the employer or insurer.

Three principal methods are used to settle non-contested claims:

1. agreement,
2. direct settlement and
3. hearing.

Most states use the agreement method, by which the injured worker and employer or insurer agree upon a settlement before the claim is paid. Some states use the direct-settlement system, by which the employer or insurer pays benefits immediately to the injured worker upon notice of disability. Finally, under the hearing method, an industrial commission or board hears the case and must approve it before the claim is paid.

Workers' Compensation Prices

Most states base their workers' compensation benefits on their statewide average weekly wage, which is most commonly calculated annually. However, states vary in the way they set benefits. Oklahoma, for example, recalculates its average weekly wage every three years, while Wyoming benefits change quarterly. Some states set maximum benefits by statute, and those benefits remain in effect until changed by the legislature. In most states at the present time, workers' compensation insurers use the rates developed by the National Council on Compensation Insurance.

Prior Approval Rating

These rates must be approved by state regulatory officials, and workers' compensation insurers must use these rates, subject to any rate deviations allowed under state law. It is argued that approved rating has worked well over time since rates are established for numerous occupations and trades that are ranked according to their risk or hazard level. The rates are based on a broad range of national loss data. Prior-approval rating means that workers' compensation rates are determined for the various occupations and classes by the National Council on Compensation Insurance.

Competitive Rating

In contrast, competitive rating or open competition means that workers' compensation insurers are free to develop their rates based on the competitive market system. A company would be free to establish and charge a particular rate without first obtaining approval from state regulatory officials.

Supporters of the present system of approved rating argue that adoption of a competitive rating will result in several adverse effects. They include the following:

Safety may be undermined. Emphasis on low workers' compensation rates may force companies to drop the additional expense of providing loss-control services and rehabilitation programs to firms. Since safety services may decrease, future workers' compensation claims could increase.

Small policyowners will be adversely affected. Critics also argue that under competitive rating, workers' compensation insurers would rate small firms on the basis of individual loss experience. Thus, smaller firms with a high loss potential would pay much higher premiums for their workers' compensation coverage than they are now paying.

Small insurers would be adversely affected. Under competitive rating, individual companies must have their own staff of experts to estimate the costs of any benefit changes in the state. Many insurers would have to hire additional persons with the necessary actuarial and underwriting expertise. Many smaller insurers would be confronted with a substantial increase in expenses and may lack the financial resources to develop their rates. It is argued that, ultimately, many smaller companies would not be able to compete and would withdraw from the workers' compensation market. This would leave only a small number of large companies to write the coverage.

On the other hand, supporters of competitive rating point out certain advantages that will result from a competitive rating system. They include the following:

Price competition will lower rates. It is argued that, under approved rating, there is little incentive to reduce rates, even when loss experience is favorable. However, under competitive pricing, it is argued that there would be greater price competition, which would tend to lower rates. For example, Michigan's open competition law became effective in 1983. The law resulted in net savings to employers of about 30 percent in 1984. However, by 1985, savings had declined to 20 percent or less.

Government involvement would be reduced. Since rates would not have to be approved by state regulatory officials, government involvement in the insurance industry would be reduced. This is consistent with the present national trend of reducing the role of government in the economy.

Product innovation would increase. Eliminating the present system of administered pricing would stimulate the development of new programs and products in workers' compensation insurance. Thus, policyowners would have a greater opportunity to select their own combination of product, price, and service. In addition, insurers would be able to respond quickly to changing loss and loss experience.

At the present time, there is great emphasis on a reduction in the role of government in the economy, deregulation of key industries, and free and competitive markets. Thus, there may be greater pressures placed on the states to pass open competition rating laws by which competitive rating based on the free market can prevail.

IV. PART IV– THE REGULATION OF INSURANCE

History of Regulation

The history of insurance regulation has its roots in 17th-century England; however, the controversial and highly contested route of its development has resulted in a regulatory structure that is uniquely different than that found in other industries. There is no question, however, that the activities of American insurance companies are highly regulated, and few other businesses are guided by the strict controls and guidelines found in this industry.

To illustrate, an insurance company cannot establish operations without specific and regulated levels of operating funds. Other businesses do not have these start-of-business requirements. Similarly, insurance products must be sold by agents or brokers only, while other businesses may market their goods and services through whatever means they elect to use. Only the insurance industry must have its rates approved by the state in which it is operating, while other businesses are free to set their own prices and rates. Finally, regulations require insurance companies to maintain certain levels of funding (reserves) for the protection of their consumers.

Generally, in most other industries, the state regulatory focus becomes secondary to federal regulation as an industry matures, but the insurance industry in the United States has moved away from a centralized federal regulatory structure, and the concentration of regulation has been passed to state governments.

Although the states exerted little control over insurance businesses before the Civil War, several states established statutes requiring charters for the insurers selling products within their boundaries. These charters and their provisions restricted insurance company activities and offerings, specified reserves, and established parameters regarding investments.

This was the first attempt to regulate the U.S. insurance industry. In some states, chartering bodies directed insurance companies to make their financial standings public, while others required insurers to publish annual reports. Companies in Massachusetts were mandated to make these reports public as early as 1818. Other states soon followed this lead, asking for annual reports from state-based insurance companies and requiring insurers outside the state to make statements of their financial condition available. Other than these parameters, the insurance businesses of the time were allowed to operate as they chose.

While these chartering mechanisms provided regulatory guidelines for the industry, little was available in the way of enforcing these guidelines. The states were adept at issuing charters and often appointed various departments to tax their earnings from premiums, but the administrators assigned to regulate insurance businesses in certain states were not always effective in policing the industry regarding legislation.

As a result, some companies made poor investment decisions and squandered their funds. Others simply went bankrupt. Still others used deceptive and unfair policy provisions. This roller coaster track record made it obvious that some type of regulation was necessary for the protection of the public. It also indicated a need for regulation to balance business activities and sustain the industry.

To more efficiently empower state regulatory offices, New Hampshire was the first state to establish a three-seat insurance commission in 1851. The board was later reorganized to include a single commissioner in 1869. Other states followed, and today, the state insurance commission continues to exercise substantial influence within the insurance industry.

In 1855, the state of Massachusetts established the first department of insurance, and in 1858, appointed mathematics professor Elizur Wright as insurance commissioner. Wright would later be credited as the person who contributed most to the future of insurance supervision, due to his concept of regulation for the purpose of insurer solvency.

Shortly after New Hampshire created the first insurance commission, the U.S. House of Representatives proposed a bill to establish a national bureau of insurance as an adjunct of the Treasury Department. Two years later, the Senate passed a similar bill. Both were defeated, however. The reason for the failure of the two bills, it was speculated, was that the country was not yet ready to embrace the idea of federal control of the insurance industry.

In the early 1900s, the effectiveness of the regulation of the insurance industry was studied by two separate committees. The New York legislature appointed a committee, the Armstrong Committee, for the purpose of studying the life insurance industry in 1905. The committee reported finding several areas of abuse regarding financial reporting and other wrongdoings resulting from the lack of effective regulation.

In 1910, the New York legislature appointed the Merritt Committee to investigate non-life insurance lines.

This committee reported that price competition would result in rate wars that would be devastating to the industry. It noted that insurers that had only marginal operations would be forced to offer coverage at a slightly lower rate, and that those insurers with stronger operations would respond to these decreases by lowering their rates. Eventually, this would create a problem for the margin insurers, which would result in bankruptcies. This study reported that cartel insurance pricing was acceptable for the public good as well as for the good of the industry.

In most states, the insurance department is part of the executive branch of state government, and it is under the direction of the insurance commissioner. In a few instances, this is an elective position. However, in other states, the governor appoints the commissioner. The commissioner's main duty is to administer the insurance laws of the state, with the assistance of staff members. In most states, the insurance department is represented by a force of anywhere from 50 to 100 people.

Formation of NAIC

Paramount to the success of the state departments of insurance is the National Association of Insurance Commissioners, a non-governmental body developed to coordinate the activities of the individual state insurance departments. Founded by George W. Miller, the second superintendent of insurance for the state of New York, the early goals of the NAIC were those of uniformity of examination practices, annual reporting statements, and laws.

The first meeting of the body was in 1871 and included all of the insurance commissioners of the state. It became a voluntary organization, and through the guidance of the NAIC, the state departments began to avoid the confusion of uncoordinated operations.

Today, the NAIC meets twice yearly, with regional meetings scheduled between meetings of the entire NAIC body. Various committees from the organization work throughout the year on specific topics. Much of the committee work is focused on standardization procedures and formats, but others have developed information included on policies and policy statements.

As a body, the group is committed to the development of legislative recommendations. Once the need for a new law is identified, a specific committee studies the situation and makes a recommendation to the larger group. If the group can pass the measure, it is submitted to the legislatures of the states involved in the form of a model bill for discussion. Although some states eventually reject some of these legislative proposals, the process has resulted in a growing uniformity of the industry's regulation throughout the country.

The NAIC continues to study the problems and changes within the industry. Task force groups use advisory committees made up of insurers and the public-at-large to investigate issues and ideas to improve the industry as a whole. In the 1980s, for example, the NAIC task force gave primary attention to the use of gender and marital status as classification factors used in automobile insurance ratings and comprehensive health insurance coverage. They also looked at the question of state versus federal insurance regulation and ways to detect insurer insolvency before it occurred.

Why Regulate?

The question of regulating the insurance industry is ultimately answered by the fact that the insurance industry is "affected with a public interest." This concept was initially developed by the British jurist Lord Matthew Hale in 1676. The U.S. Supreme Court used Hale's concept as a basis for writing its own decisions and determined that the insurance industry was deemed "affected with a public interest" because of its role in many other business and industry activities.

Two hundred years later, in the case of Munn v. Illinois, the Supreme Court further determined that insurance companies were businesses affected by the public interest. In its ruling, the Court recognized the states' rights to regulate "properties" affected with the public interest but protected these "properties" or businesses by further stating that the courts, not the legislature, would be responsible for determining "reasonableness."

Munn vs. Illinois became a landmark ruling because it specified that property was "clothed with a public interest when used in a manner to make it of public consequence and affects the community at large." However, no specific consequences were delineated in the ruling, and in its final form, the public interest concept became a dynamic one that would vary with court opinions down through the years.

The case of Paul vs. Virginia in 1869 determined the legal basis for state regulation of the insurance industry. Samuel Paul was a Virginia insurance agent for several New York fire insurance companies. In Virginia at that time, insurance agents representing out-of-state companies were required to provide certain information to the state controller's office. Paul had not met these requirements. The result of his noncompliance was a $50 fine. When Paul appealed the fine, he argued that the insurance business was commerce, and in his case, interstate commerce. The U.S. Constitution, in his interpretation, controlled interstate commerce, and according to Paul, Virginia's requirements of the insurance industry were highly unconstitutional.

The Supreme Court rejected Paul's argument, ruling that selling insurance policies was not commerce, but personal contracts, not merchandise that was being shipped from one state to another. In their ruling on Paul vs. Virginia, the Supreme Court upheld the Virginia laws and ruled that insurance companies were not to be regulated by the federal government, but by the states.

Paul ultimately lost his fight and had to pay the $50 fine, but the case determined the right of the state governments to regulate insurance companies, a ruling that was held intact for the next 75 years.

In part, the ruling stated:

"... issuing a policy of insurance is not a transaction of commerce. The policies are simple contracts of indemnity against loss by fire, entered into between the corporations and the insured, for a consideration paid by the latter. These contracts are not articles of commerce in any proper meaning of the word.

They are not subjects of trade or barter offered in the market as something having an existence and value independent of the parties to them. They are not commodities to be shipped or forwarded from one state to another and then put up for sale. They are like other personal contracts between parties that are completed by their signature and the transfer of consideration. Such contracts are not interstate transactions, though the parties may be domiciled in different states.

The policies do not take effect—are not executed contracts— until delivered by the agent in Virginia. They are, then, local transactions and are governed by the local law. They do not constitute a part of the commerce between the states any more than a contract for the purchase and sale of goods in Virginia by a citizen of New York whilst in Virginia would constitute a portion of such commerce."

In the early 1900s, it was proposed that certain aspects of the insurance industry be placed under federal regulation. However, the judiciary committee advised the U.S. Congress to refrain from passing such legislation, basing their arguments on the fact that Paul v. Virginia and other cases had determined that the federal government had no documented authority over the industry. It was not until 1944 that the Supreme Court reversed its Paul v. Virginia decision and ruled in the South-Eastern Underwriters Association case that the insurance industry was indeed commerce.

In 1945, however, the U.S. Congress passed the McCarran Act. This act stated that the states should continue to regulate the insurance industry because it was in the public interest, and further specified that the antitrust acts only apply to the insurance industry in instances where state regulation is not effective. But if the state regulatory body is strong and adequately regulates the industry in that state, federal antitrust laws would not be applicable.

The McCarren-Ferguson Act was accompanied by a report from the House Judiciary Committee, which stated:

"Nothing in this bill is to be so construed as indicated it to be the intent or desire of Congress to require or encourage the several states to enact legislation that would make it compulsory for any insurance company to become a member of rating bureaus or change uniform rates. It is the opinion of the Congress that competitive rates on a sound financial basis are in the public interest."

There have been numerous rulings and many more theories and explanations regarding the purposes for regulation, but one of the most often quoted is the hypothesis of Spenser Kimball, who reduces the objectives in the regulation of insurance to two:

- to assure that the industry is sufficiently solid financially to meet the expanding demand for coverage, and
- to assure that the industry operates with a sense of fairness, equity, and reasonableness in the marketplace. The first objective Kimball calls "solidarity." The second, he calls "aequum et bonum."

According to Kimball, if each of the reasons for regulations were examined individually, there would not be sufficient reason for the extreme regulation of the industry as it stands today; however, he emphasizes in his writings that most principal members of the insurance profession welcome the regulation because it controls the environment within which the industry operates.

Purposes of Regulation

In the objective examination of insurance regulation, the primary purpose is the protection of the consumer public.

In all areas of the insurance industry, public confidence in the established system is requisite to the maintenance and ultimate success of the business. If the public should lack confidence in the industry because of experiences with fraudulent and incompetent insurers, the system would eventually fail. This lack of confidence would occur if the insurer became unable to provide the coverage promised. In cases of insolvency, the consumer would forfeit both the price of the policy and the expected reimbursement for loss of property, disabilities, medical expenses, or the support of dependents.

To establish and maintain consumer confidence, certain regulatory goals have been developed to combat negative and unscrupulous business activities within the industry in order to prevent insurer insolvency, prevent fraud, assure reasonable pricing, and increase the availability of insurance. Each of these goals will be explained in detail.

Insurer Insolvency

One of the primary goals of insurance regulation is to prevent insurance companies from going into bankruptcy.

To this end, controls have been established through government regulations unique to the insurance industry. These controls require insurance companies to maintain certain levels of operating capital, as well as specified reserves and surplus levels to underwrite "the future services" agreed upon in the policies issued by that company. The government requires insurance companies to meet these levels because of the far-reaching effects of an insurance company going bankrupt. What could be the explanation behind this regulation?

When any other business fails, investors in that business lose their money and people lose their jobs, but the bottom line of a business failure is something called competition—a major aspect of our free enterprise system. Sometimes a business goes bankrupt because it is not offering goods and services at a reasonable price to the consumer. When a business folds, the competition absorbs its customers and may adjust goods and prices to remain within the good graces of the consumer public. In this scenario, both the competitor and the consumer benefit. When an insurance company fails, there are no similar beneficiaries.

The other major aspect to be considered in understanding regulations for the prevention of bankruptcy in insurance companies is this: insurance premiums are based on what the insurer estimates the cost of future services will be. If the estimated costs of these services or losses are lower than the actual costs, the result is that rates are set too low, and policies are underpriced.

Several decades ago, the industry underestimated the impetus of rising rates in liability claims for property-casualty policies. A few years later, this area of the industry experienced significant losses because of the underpricing.

Because the industry must estimate future trends and activities, there is always the possibility that rates may be inadequate to cover losses. This fact, coupled with the far-reaching impact of insurance company failure, forms the logic of regulation to protect the industry from insolvency.

Prevention of Fraud

The prevention of fraud is also a primary goal of government regulation because it protects the consumer against being misled or misinformed by an insurer. As has often been pointed out by the industry, as well as public advocates, insurance policies are extraordinarily complex, technical documents that few laypeople understand. Without regulation, there would exist the possibility that, at some time, an unscrupulous insurer could include certain phraseology that would mislead the insured and save the insurer from paying a particular claim.

The second aspect of regulation for the purpose of preventing fraud concerns an insurance company's continuing solvency. To continually strengthen its consumer base, a company will advertise itself as a strong and reliable firm with well-invested funds. To provide the consumer with some protection against fraudulent claims of this type, states monitor a firm's operations to ensure that no false claims may be made.

Reasonable Pricing

A third goal of regulation is to protect the insurance consumer against excessive rates.

Like regulations to protect the consumer from fraud, this type of regulation is also unique to the insurance industry. If an insurer decides to increase rates, it must first file its intentions to raise rates with the state commissioner. If there are objections, no rate increases may occur.

This, too, is a regulation unique to the industry and is explained by the law of large numbers. Because the insurance industry is based on past experience and certain statistics, the assumption is that the future will be much like the past in these terms. Rates, therefore, are based on the past experiences of many insurers. These collective rates, of course, would be more reliable than the rates based on the past experiences of a single insurer.

Given this assumption, the insurance industry is not required to comply with the anti-price fixing aspects of antitrust laws but, instead, may establish its prices based on its collective experience. With rates established through regulation, the resulting competition works to maintain reasonable pricing within each state's industry.

Insurance Availability

Making insurance available to all who need coverage is the final goal of regulation.

This pledge to the consumer public is the basis for the establishment of automobile insurance pools in the states to make liability insurance available to those drivers considered to be high-risk and not otherwise able to obtain insurance from standard insurers.

Insurance is also made available to a broad-based market through federal programs that reinsure those companies that offer property and crime insurance in high-risk situations. And because increasing liability claims have raised the cost of professional malpractice insurance, government regulations have also been put into place to continue making this insurance available to all who require it.

As more insurance is becoming a necessity for families in the 1990s and into the next century, there is an ongoing debate as to whether insurance companies should be regulated to the point that they have no choice as to whom they insure. Some argue that the government should underwrite protection, such as Medicare, particularly for those deemed to be a risk for the private insurance company to insure. The opposing side believes that insurance companies should be forced to make coverage available to all who require it. The debate continues.

Legal Cases and Implications

The South-Eastern Underwriters Association

In 1944, the Supreme Court ruled on the South-Eastern Underwriters Association and, in a surprise move, reversed the Paul v. Virginia decision. The SEUA was a rating bureau with approximately 200 members (representing about 90 percent of the fire insurance lines) and was located in Atlanta, GA. The SEUA had been charged with violating the Sherman Antitrust Act because it was believed that it was monopolizing the fire insurance business.

The indictments brought against the SEUA included those for restricting interstate commerce by fixing non-competitive rates on fire and other related insurance lines and monopolizing commerce in insurance. The SEUA also had charges against it for fixing commissions, compelling consumers to buy only from SEUA members, and using boycotts.

Attorneys for the SEUA argued that, based on Paul v. Virginia, insurance was not commerce and therefore not governed by the Sherman Antitrust Act. The court determined that insurance was indeed commerce and subject to control by the federal government. This ruling, in turn, subjected the insurance industry to the terms of the Sherman Antitrust Act, and the court determined that cooperative pricing by the 200 rating bureau members was illegal.

It is important to note that the Supreme Court received criticism for deciding a question about the U.S. Constitution without a majority vote; however, with a vote of 4-3, the decision stood— the insurance industry was now officially subject to federal regulation.

The opinion itself concluded:

"Our basic responsibility in interpreting the Commerce Clause is to make certain that the power to govern intercourse among the states remains where the Constitution placed it. That power, as held by this Court from the beginning, is vested in the Congress, available to be exercised for the national welfare as Congress shall deem necessary. No commercial enterprise of any kind that conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make exception of the business of insurance."

The confusion caused by the SEUA decision led to the belief that there was a penalty for disobeying state laws that require rate-making organizations, but going along with them would cause one to violate the Sherman Antitrust Act. However, nothing could be further from the truth. Only state laws that did not run counter to federal legislation applied because the rest were nullified by the ruling of the SEUA. One fact was made clear: the states' rights to regulate insurance were never challenged by the SEUA ruling.

In his written opinion, Justice Black pointed out: "Another reason advanced to support the result of the cases that follow Paul vs. Virginia has been that, if any aspects of the business of insurance be treated as interstate commerce, 'then all control over it is taken from the states and the legislative regulations that this Court has heretofore sustained must now be declared invalid.' Accepted without qualification, that broad statement is inconsistent with many decisions of this Court. It is settled that, for constitutional purposes, certain activities of a business may be intrastate and therefore subject to state control, while other activities of the same business may be interstate and therefore subject to federal regulation. And there is a wide range of business and other activities that, though subject to federal regulation, are so intimately related to local welfare that, in the absence of Congressional action, they may be regulated or taxed by the states."

Public Law 15

The states' authority to regulate the insurance company was clarified through the SEUA decision, but while the opposing sides awaited the Court's opinion, Congress introduced the Bailey-Van Nuys bill to establish their intentions for the states to continue to regulate insurance, making the industry exempt from the Sherman and Clayton Antitrust Laws.

The members of the rating bureaus supported the bill because they did not want the antitrust laws to apply to their activities. Members of the NAIC and the "independents" (nonmembers of the rating bureaus) wanted to do away with the monopolistic activities they perceived in the industry, so they were against the bill. The bill did not make it past the Senate and ultimately failed, but later, other proposals followed that were eventually the McCarren-Ferguson Act, or "Public Law 15."

This law stated that the states' regulation of the industry was, indeed, in the public interest, and for this reason, the industry was exempted from the provisions of the antitrust laws until July, 1948—the date fair trade and antitrust laws applied to those parts of the industry not regulated by the states. However, according to Section 3(b) of Public Law 15, "... nothing in this act should render the Sherman Act inapplicable to any agreement to boycott, coerce or intimidate, or act of boycott, intimidation, or coercion."

The report accompanying the act stated:

"Nothing in this bill is to be so construed as indicating it to be the intent or desire of Congress to require or encourage the several states to enact legislation that would make it compulsory for any insurance company to become a member of the rating bureaus or charge uniform rates. It is the opinion of Congress that competitive rates on a sound financial basis are in the public interest."

Some interpreted this law to mean that only insurance companies volunteering to become part of a rating bureau in a state-regulated environment were sanctioned. However, the Allstate, et al. vs. Lanier, et al. case ruled that the law requiring all automobile insurance companies in the state of North Carolina to become members of the North Carolina Rating Office was not in conflict with the McCarren-Ferguson Act. In this ruling, the U.S. District Court stated that the state was so "authorized" and could go into further depths of regulation if the legislature decided to do so. Therefore, the states were given the right to limit competition if they chose to do so. The Supreme Court declined to review the case.

The U.S. vs. Insurance Board of Cleveland

Before the SEUA case, certain rules were locally enforced that would be illegal under the Sherman Act. These rules, which were introduced by stock agents' associations, included boycott, coercion, and intimidation. Both insurers and agents were affected by these rules that effectually curbed competition. Among other limitations, insurance companies were allowed to have a certain number of agents in an area. Further, they were limited to reinsuring member insurers. Members were also not allowed to represent nonstock insurance companies, insurance companies that wrote policies directly (bypassing agents), companies selling established below-bureau rates, and companies whose agents were not members of the association.

Although the National Association of Insurance Agents decided to refrain from reinforcing these rules, certain local associations continued to use the rules, causing challenges from the Justice Department. Such was the rationale behind The U.S. vs. Insurance Board of Cleveland and a similar case pitting the department against the New Orleans Insurance Exchange.

The two boards said that the tenets of the McCarren Act had nullified the antitrust laws, but the court rebutted that nothing in the McCarren Act had suggested that the Sherman Act was not applicable, particularly in instances of boycott, coercion, or intimidation for the purposes of limiting competition.

Challenge — U.S. Securities and Exchange Commission

The challenge from the U.S. Securities and Exchange Commission came when the specific definition of what constituted the "insurance business" began receiving scrutiny because the McCarran Act applied only to the insurance industry. It was questioned whether annuities were classified as part of the "insurance business." It was cited that both the Securities Act of 1933 and the Investment Company Act of 1940 had granted a specific insurance exemption to annuities.

However, the courts ruled that variable annuities are not insurance because the issuing company would have "... no true risks in the insurance sense." The upshot of this ruling was that life insurance companies that issued variable annuities were, therefore, under the jurisdiction of both state and federal regulations—the annuity being treated as a security and the separate common stock account as an open-ended investment company. Also exempt from the Securities Act of 1933 and the Investment Company Act of 1940 were separate accounts with proceeds used to fund retirement plans for self-employed individuals. However, variable annuities issued under these same retirement plans were to be regulated as indicated by the Securities Act of 1933.

In the interim, other rulings have been made that would be counter to some of the original rulings of earlier court decisions. It is important to realize that with the many new products introduced by insurers over the past several decades, additional court cases are heard every year. The resulting rulings affecting the regulation of these products must be reviewed and understood by corporations and agents in order to maintain the ethical standards of the industry.

Reasons for Regulation

From its beginnings, the insurance industry has had ample time and opportunity to diversify itself regarding products, services, and methods of marketing. Today, it provides numerous services to its patrons, delivering these in a variety of formats—formats that respond to the various and emerging needs of the public it serves. All, however, are strictly regulated, and, within the industry today, the complexities of its business are divided into three major areas of regulation:

1. The financial strength of the insurer,
2. Products, and
3. Sales and sales practices.

What's Regulated?

The Financial Strength of the Insurer

In order to ensure the solvency of the insurer, numerous regulations are required to control aspects of the business, such as rates, expenses, investments, surplus, dividends, organization, annual reports, and liquidation of insurers. Specific levels of capital and surplus are required before insurers can open their doors for business. Once these requirements have been met, regulators have ongoing expectations of the insurer to maintain an adequate cushion of operating capital and surplus to respond to any unexpected declines in investments or the burden of claims.

All insurers are regulated against highly speculative investments or those that fall in the high-risk category. This type of regulation limits the percentage of any insurer's assets that may be committed to investments in stock or real estate. This, in turn, may also limit the company's ability to build capital at a rapid rate.

A company's reserves are also regulated and must always be adequate to meet obligations that may arise in the future. Each state has its own formula for calculating reserves to cover each type of policy.

Regulation of Products

Over the years, the insurance industry has become so complex that policies are often the subject of court interpretation. Because of these complexities, it is difficult for the average policyholder to understand even a basic policy, which allows for unscrupulous agents to write policies that may not be in the best interest of the insured. In some cases, even honest insurers may inadvertently include exclusions and special provisions that may be misleading or unfavorable to the policyholder.

Because of this situation, and because it is generally felt that most insurance policies are often difficult to understand, there has been a movement in place for several years to simplify policy formats. One rate advisory bureau filed a homeowners policy reducing the narrative by about 40 percent and increasing the size of the type used in the policy by 25 percent. More white space was also allowed between the lines. More readable policy guidelines have also been instituted for automobile, business, personal, life, and health insurance policies.

Certain state insurance commissions have also instituted guidelines regarding insurance policy forms. In doing so, they are attempting to protect both the policyholder as well as reputable insurers against policies that are ambiguous, deceptive, or so difficult to understand that they could be misleading. Certain formats of life and health insurance policies are prohibited from use, and the commission reserves the right to disapprove policies that contain unjust, inequitable, deceptive, or misrepresentative provisions. The problem arises because most state commissions do not have the funding or the personnel to carefully review all policies.

Regulation of Sales and Sales Activities

The purpose of this type of regulation is, at first glance, to protect the consumer from unreliable services and disreputable agents. However, the regulation also serves to provide a balance of fair competition within the environment. In this area of regulation, the states regulate how insurers obtain new policyholders, the ethical standards within the industry, and the standards required of insurance sales agents.

Every state requires certain standards from those selected to sell or broker insurance. Qualifications for licensing range widely, but an increasing number of states require insurance salespersons and brokers to sit for a written examination. Some require formalized training before sitting for the examination.

Other states require no training, assuming that the agent will gain knowledge through on-the-job experiences. Once the examination is passed and the license is issued, the agent or broker must continue learning about the field through continuing education requirements each year. This continuing education or training may be taken individually or through the attendance of seminars. Most states require continuing education in order to reissue the agent's or broker's license.

There are a few states that do not require any additional training, and re-licensure is automatic.

Once a salesperson has been licensed, that individual's activities may also fall under regulation, particularly if those sales activities drift into the realm of misrepresentation. Most of the states have statutes that prohibit misrepresentation of the facts about a policy and its coverage. Some statutes also cover the parameters of the relationship between the insured and the insurer.

In the insurance industry, the term "twisting" refers to the misrepresentation of the facts by an agent in order to manipulate the policyholder into substituting one contract for another. Twisting also includes the failure to include all the facts when policies are represented.

Because of the regulation against twisting, agents are discouraged from making recommendations that may include dropping one policy in favor of another. Neither misrepresentation nor twisting is easily documented or easy to prove, and, generally speaking, both activities go undetected and, therefore, unpunished.

To further refine the regulation against twisting and replacement, the National Association of Insurance Commissioners developed a bill that mandates that any policy that could be replaced would have the ability to evaluate and rebut any comparative information received by the policyholder.

Another sales activity that is regulated against is that of rebating, where an agent would refund part of the premium to the policyholder. In most states, anti-rebating regulations have been established for the purpose of protecting the public interest. Rebating is difficult to prove and, therefore, few cases of rebating are ever heard in court.

Unfair discrimination is a situation in which someone is offered a lower rate than others experiencing the same conditions. In cases of unfair discrimination, the unfairness of this activity is emphasized because the insurance industry, as a whole, should be discriminatory in its exposures to loss possibilities.

Methods of Regulation

Historically, self-regulation was the first type of formalized insurance regulation and continues to be the most powerful form of industry regulation in both the United States and Great Britain. This form of regulation has maintained its power because of the fear of more public reaction against individual insurers. Therefore, it has been advantageous for industry professionals to seek and obtain additional self-regulatory powers that support the public interest.

Under the current system, the insurance industry is also subject to three distinct types of regulation executed by the three branches of the democratic form of government— legislative, judicial, and executive. These three methods of regulation, plus the self-regulatory structures, oversee specific areas of operations within the industry and distribute regulatory powers between state and federal regulatory agencies. The following paragraphs will examine and explain the distinctions of each of the four categories.

Legislative Regulation

All insurers and their operations in the 50 states, the District of Columbia, and Puerto Rico are governed by insurance laws and regulations. The states legislate these guidelines for matters such as agent licensure, methods of doing business, the availability of coverage, and other aspects, and they have police power to enforce the rules protecting the health and welfare of the citizens of that state once they are approved.

Regarding insurance, the states do not leave the development of legislation totally to legislatures. Associations of insurers and other individuals and groups are encouraged to develop model bills and submit them for legislative sponsorship.

Judicial Regulation

Through their interpretation of legislation and other questions, the judicial branch of each state plays a key role in the legislation of the industry. Although their involvement is often indirect, the courts are also employed to settle disputes between parties involved in insurance contracts. The written ruling of the court for each case, therefore, becomes a part of the body of legislation regulating insurance.

Executive Regulation

As the insurance industry became more diversified and complex, it became obvious that the industry's regulation should be supervised by knowledgeable and experienced individuals. No longer could lawmakers be charged with regulating this rapidly growing business. To fulfil the administrative needs, each state has established an insurance department headed by a commissioner. Commissioners make rules, called administrative law, to ensure the successful operation of the industry within their state. However, these rules and these individuals are, in turn, accountable to the review by the courts.

The duties of state insurance commissioners are broad and varied, but each state insurance department has certain basic duties. These include licensing of insurance companies and agents working within the state, monitoring the activities of licensed agents, and screening these activities regarding good business practices. In some cases, the commission is required to mete out certain penalties for unscrupulous behavior, such as the revocation of licensure or the closing of businesses that fail to meet regulatory requirements regarding reserves, capital, and surplus.

Since 1818, when the Massachusetts insurance department required the filing of the first annual financial reports, state commissions have required the filing of annual statements; furthermore, they function as a depository for securities in states with laws governing securities and require an evaluation of corporate assets on a regular basis.

The commissions also regulate trade practices and oversee and approve policy contracts. In its role as a regulatory body, the commission may also monitor rates to ensure against discrimination. The state investigates complaints on all levels and maintains strict controls on any mail-order insurance activity in the state, as outlined in the Unauthorized Insurers Process Act.

To be considered for the position of state insurance commissioner, industry-watchers believe this individual should be experienced in the industry, competent, and accustomed to working with even the most technical aspects of the business. Commissioners should also be astute decision makers and skilled tactical managers, as well as politically astute. Further, it is believed that future commissioners will be required to have more sophisticated skills and experiences than those serving today. Examples of these future requirements include the increasing international emphasis of American business and the growing global elements of the economy that, in turn, contribute to increasing demands and bring growing complexities into the industry.

Self-Regulation

Once regulations were in place from governmental sources, the instrument of self-regulation re-emerged from a growing "consciousness," or an awareness by special groups of the disadvantages of more and greater outside interpretation and regulation. Because of this, the insurance industry has continued to be a self-regulated industry to a certain degree. Through associations of insurers and agents, these self-regulatory groups have exerted some degree of control through strict codes of ethical conduct and other cooperative agreements. These groups continue to function, generally out of the fear that more public regulation would impair the industry and its purposes. In England, self-regulation continues to be the only form of control practiced by British insurers.

State and Federal Regulatory Agencies

Main Areas of Regulation

Today, American insurance companies provide a variety of services for their clients, and they also offer numerous products that meet the needs of the many groups they serve; however, each of these products and functions is highly regulated. The following is a brief overview of the primary areas of regulation within the industry and how regulation is enforced. These areas include financial regulation, product regulation, and regulation of how companies conduct their business.

The area of financial regulation is the largest area of control within the insurance industry. It is also the most important because of the importance of financial solvency. Financial regulatory laws affect not only the reserves and assets of the insurance companies across the country, but also the basic organization of the companies, their investments, the valuation of assets, and rate-setting mechanisms.

Product regulation is, indeed, a critical area of regulation because most insurance purchases are made without the benefit of any knowledge of the industry. In some cases, policies are written so that few laypersons actually understand the total scope of coverage or the provisions, both favorable and unfavorable to the insured. Because of this situation, and to cut down on the number of consumer fraud cases, some states have asked insurers to make the language of their products easier for consumers to understand. This request has brought new, readable homeowner policies into as many as 30 states, and readable policies have also been developed for other product lines.

The regulation of business methods in the insurance industry is a third area of interest because it protects purchasers from unscrupulous agents and, at the same time, protects the fairness of competition. Specifically, the states tend to regulate the methods by which insurance companies seek, prospect, and finally sign on new policyholders. The regulations in force include those safeguarding ethical standards and a full investigative team to examine consumer complaints regarding the activities of insurance companies and their agents.

Regulation of Finances

The regulation of insurer expenses is a typical area of financial regulation. With the SEUA decision, organizations control commission rates, and if rate wars occur, it is within the jurisdiction of the state insurance commissioner to regulate the situation. Life insurance expenses are regulated in several states, with New York law being the most complex. This law places caps on expenses and the cost of acquisitions, and affects approximately 70 percent of the life insurance sold in the United States. The New York law features:

- Restricted commission and fees on individual policies.
- Controls on awards or prizes for volume business.
- Complex limits on field expenses.
- Maximum caps placed on renewal commissions and service fees.
- Training allowances for new agents that are commission-approved.

Regulation of Admitted Assets

The solvency of an insurance company is measured by how much admitted assets surpass the company's liabilities. This measurement is taken by state regulators. Valuations for the company are highly regulated, which makes the insurance industry, once again, unique from most corporations.

In most situations, "admitted assets" are those assets held by the company that include legal portfolio investments. Admitted assets always include office buildings and real estate (some states also allow computer equipment), but do not include operational assets for the firm—assets such as automobiles, supplies, furniture, and other capital expenditures, or secured or unsecured loans and advances to agents.

It is often easier to value some admitted assets than others. For example, cash and bank accounts are valued at face amount, but there are other criteria for most other holdings.

Examples of this are:

- **Real estate**—valued at book value or market value.
- **Mortgage and collateral loan**—amount of outstanding debt.
- **Bonds**—amortized value if they are secured by earning power.
- **Bonds in default**—market value as instructed by the Committee on Valuation of Securities of the NAIC.
- **Stocks**—values prepared by the Committee and equal actual market value as of December 31 of that year.
- Open accounts and premiums to be collected are valued at book value.
- Bad debts are then estimated and deducted. With these guidelines, it is not the insurer who can pay claims within a reasonable period that is counted as solvent, but rather the insurer whose admitted assets are equal to or exceed their statutory liabilities.

Regulating Rates

While the level for rates on individual life policies, most health policies, and ocean marine insurance are not regulated, there is a minimum set for group life by several state insurance departments. Property and liability rates are controlled by model rating laws.

These regulations are based on historical records of prospective loss and expense, as well as the occurrence of catastrophic events and hazards within a certain area. When there is regulation of this sort, the insurance company must file premium rates, rating plans, coverage, and rules for approval by the commissioner or a special committee. In this filing, the company must also provide support for any calculations with documentation.

Some insurers will go through a licensed rating organization rather than filing directly with the state commissioner; however, the commissioner can also disapprove any filing, as long as they specify reasons why the filing was disapproved.

Each state commission must also approve a rating organization, and each rating organization must allow any qualified insurance company to take advantage of its services, without any discrimination against the company. There are technical requirements built into methods of recording and reporting loss and expense experience, exchange of rating plan data, and consultation with other states, and the state commissioner usually taps a rating organization to collect this data.

Unless a company files an application for deviation, each subscriber must follow the rating organization's rates and policies, but the commissioner may also disapprove these applications if there is a hint of inadequate, excessive, or discriminatory rates.

Regulating Automobile Insurance Rates

Observers of the insurance industry have often pointed out that the regulation of automobile insurance rates has taken on a political aspect, because state department commissioners are more focused on whether the standard is excessive as opposed to the standard being adequate. One such observer suggested that the political careers of the regulators in one state were more important than the financial solvency of insurers in that state.

The problem apparently comes when the public pressure for lower auto insurance rates takes precedence over the financial strength of the insurance companies, and therefore, some states continue to walk a tightrope between these two priorities. Notably, in one state, when a commissioner voted to increase automobile insurance rates, that person was quickly fired by the incumbent governor who was running for another term.

Property-Liability Insurance Regulation

In the area of property-liability insurance, many states no longer favor direct regulation of these rates. This is because:

There is an abundance of data and research behind the rates of this coverage, and because of fierce competition, there is no danger either of excessive or inadequate rating.

Because some insurance companies could charge inadequate rates to become more competitive, the state commissions are now sophisticated enough to detect those companies that could be bordering on insolvency. Because of these and other situations that are unique to property-liability rating, numerous proposals have been set forth to remove regulators from the pricing of this coverage.

These proposals have resulted in two types of rating laws: The file-and-use rating laws and the no-file rating laws. With the file-and-use law, a company could request a rate change with the documentation to support it and then use the new rate until it is disapproved by the state commission. Under the no-file laws, the insurer can request a new rate without statistical documentation and then use that rate before notifying the commissioner. In most states, there is a specified period during which the commission is notified regarding the no-file rates.

Regulating Life and Health Insurance

Valuation rules applying to the insurer's reserve liability regulate life insurance rates, and the reserve requirements are not related directly to the premium structure of life insurers. An inadequate structure will cause inadequate assets to offset the required reserves. In this branch of insurance coverage, discriminatory prices are prohibited, just as they are in property-liability insurance, yet unit prices may vary with the policy size and the insurability of the policyholder.

In other branches of the industry, competition has been an effective tool for regulation; however, in the life and health insurance branches, competition is not regarded as a useful regulatory tool because purchasers have no basis for comparison of rates and no tools to technically analyze these comparisons.

Because of the abuses (often called reverse competition) among life and health insurers, these rates are controlled by most state insurance departments. All states require that insurance companies file annual reports of loss ratios on health insurance because the public interest requires tracking of these statistics; however, the state insurance departments are not well-staffed enough to consistently check insurance company rates against the benefits offered. Some companies, however, continue to be controlled.

Regulating Reserves

This, too, is a controversial area of regulation and is probably discussed more than most of the other financial regulation categories. Those companies that write property and liability insurance should maintain both loss reserves as well as unearned premium reserves. The loss reserve is the liability for claims and settlement costs that the insurer estimates. The unearned premium reserves are those at the time of valuation that represent all policies outstanding and their gross premiums.

Medical malpractice, automobile, and workers' compensation loss reserves use the formula or loss ratio method for computing the minimum reserve, based on the previous three years and the expected loss ratio, which is 60 percent for medical malpractice and auto and 65 percent for workers' compensation.

The "sticky" area concerning regulators about loss reserves is that most insurance companies estimate loss reserves lower than practicable, and, in turn, this situation leads to insolvency when the insurer is pressed for payment. Conversely, when insurers set reserves too high, they also increase their rates to excessive proportions. And, because most state insurance departments do not have the trained personnel to "police" these areas of a firm's operations, some insolvencies have occurred because insurers have been able to hide the exact circumstances for setting their reserve percentages.

Life insurers have one principal reserve—the policy reserve. This reserve is calculated to meet all policy obligations, as well as premiums and assumed interest. The valuation on this reserve may be different from premiums charged by an insurer because it does not include an allowance or expenses, and in fact may be calculated based on a separate set of interest and mortality assumptions.

The Modified Reserve Standard is used by some life insurers because the bulk of the expense a company incurs is during the first year the policy is in effect. These expenses include premium taxes, general expenses on the part of the insurer, and mortality costs. This leaves little of the premium left for the insurer and is not enough to cover the reserve for the end of the first year.

Reserve options allow the insurer to postpone paying the full policy reserve. One such option is the "full preliminary term reserve plan." This option allows the insurer to pay no policy reserve at the end of the policy year. Each following year, the reserve amount is set for the full reserve amount on a policy written one year later for a period one year less.

The Commissioners' Reserve Valuation Method allows modification of the full preliminary term reserve system. Policies under this method are divided into two categories— Class 1 and Class 2. Class 1 policies are those that have a modified net level valuation premium that is less than a 20-pay whole life policy written for the same age at the same amount. Class 2 policies are those for which the modified net level valuation premium is more than the 20-pay whole life policy written for the same age at the same amount.

Regulation of Dividends

The payment of dividends to policyholders is usually a matter of judgment on the part of the insurer. Some state insurance departments say they control this decision by limiting the surplus amount accumulated by the insurer, not to exceed 10 percent of the policy reserve. By this type of limitation, the insurance departments effectively prevent the accumulation of a large surplus, while dividends are lower, or not paid at all. This type of regulation, according to insurance commissioners, also curbs the temptation of inefficiently utilizing a large store of assets.

Regulation of Capital Stock/Surplus Accounts

The surplus of an insurance company will be made up of surplus that is paid-in and surplus that is earned. A capital stock insurer also has paid-in capital.

The capital stock account of an insurance company is the dollar value that has been given to shares owned by stockholders. In most states, these shares are issued at a premium, or, in other words, the stock has a value that is less than the money paid by the stockholders. This creates the paid-in surplus.

Mutual insurance companies are required to have a paid-in fund minimum, but because there is no capital stock in a mutual, the fund is entirely made up of paid-in surplus. As an example, in the state of New York, the minimum for a domestic mutual insurer is $150,000 and $500,000 for a domestic multi-line insurer. Initially, these funds will be provided by lenders. These monies are then treated like guarantee funds and not liabilities. Principal is eventually repaid from the insurer's income.

Regulation of Business Capacity

If an insurance company writes new business at a fast pace, there is the possibility that this increase in business could exhaust the insurer's surplus and lead to insolvency. At the end of World War II, for example, several insurance companies actually "sold out" their products because they wrote as much business as they could without bringing their surplus accounts down to low levels. Their options: because they could not raise enough capital in a short period, the companies had to quit issuing new policies. Some insurers decided to become selective in who they insured, favoring the more profitable companies. The less profitable businesses were left without insurance. This "capacity problem" is particularly important in discussions of property-liability insurance.

Currently, the state insurance departments guard against this problem by using the following so-called rule-of-thumb: net premiums should not exceed twice the policyowner's surplus. In some circles, a ratio of 3-to-1 is used, and some states allow ratios as high as 4-to-1.

The branch of the insurance industry that does not seem destined for "capacity problems" is life insurance. The need for a large surplus is not as immediate in life insurance, and many states limit the accumulation of surplus by those companies that sell participating policies.

Regulation of Investments

Except for property-liability insurers, who experience a majority of problems in the area of underwriting, most other branches experience most of their financial problems as a result of problems with their investments. Because of this fact, most states regulate the investment of the assets of insurance companies. These restrictions may be either quantitative or qualitative—dealing with the types of investment media, the amount of security required, the percentage of admitted assets to be invested, and the percentage of admitted assets dedicated to a single area of investment, among others.

The following information will deal with specific coverages and the laws currently in effect regarding investment activities:

Life insurers—Life insurers can invest in high-grade bonds with a fixed rate of return. Limited funds can be invested in preferred or common stocks. No limit is placed on investment in qualified common stocks. Life insurers can invest in real estate for offices and branches. Real estate acquired by foreclosure must be sold within five years.

Property-liability insurers—Property-liability insurers invest assets equal to the minimum required capital in media available to life insurers. They may invest assets exceeding the required capital/surplus in stocks of solvent corporations.

Requirements for Organizing and Licensing Insurers

Each state has insurance codes that guide the development of new companies in the insurance business. Areas of the codes include:

- Developing a name.
- Notice of intention to form a company.
- Organizational structure.

These codes are in place to protect the public from being misled, from being the victims of unscrupulous businesspeople, and from people who want to profit from the sale of the insurance company's stock.

State insurance commissions have the right to regulate the types of insurance to be offered by new insurance companies, as well as the types of coverage available from this insurance.

The states issue a license to write insurance for domestic, foreign, and alien insurers, and then establish strict guidelines by which all insurers must do business in that state. The licenses issued to domestic insurance companies are usually permanent, but foreign and alien licenses are subject to renewal each year.

The state insurance commissions believe that their licensing requirements are effective in controlling the activities of all insurance companies, and to assure that they are complying with their minimum statutory standards of financial solvency, as well as to eliminate fraud or dishonesty among the insurers.

There are two laws that currently deal with unauthorized insurers (those who are unlicensed in a certain state or mail-order insurers). One of these is the Unauthorized Insurer Service of Process Act. In this act, the commissioner serves as the agent for foreign companies for service of process (the summons that brings a defendant to court for legal jurisdiction). In the second act—the Uniform Reciprocal Licensing Act, a domestic insurance company's license may be taken away if it operates in another state without a license (if that state has a reciprocal licensing act). A state may also control unauthorized insurers by limiting their business to that of licensed surplus lines or licensed brokers.

Liquidation of Insurers

When an insurance company becomes technically insolvent, the state commission of insurance takes over the company for either liquidation, rehabilitation, or conservation. The commissioner may take over operations at any time if the company is not being operated in the best interests of those holding policies with that company. An insurance company suspected of nearing insolvency has a right to a hearing by the commission, but when an order to liquidate is issued, the assets of the company become vested in the commission. At that point, if the need for a takeover is not sufficiently supported, the assets are returned to the company's management.

The Uniform Insurers Liquidation Act has been approved by several states and provides a uniform procedure in liquidation cases where insurers have done business in more than one state. This gives each state equal rights in the handling of claims and the final distribution of the insolvent company's remaining assets.

Regulation of Products

To maintain a certain amount of control over the policies offered by various insurers, the state commission must approve policy forms. This makes it difficult for companies to either mislead or deceive the consumer with statements that contain highly technical terminology or ambiguous descriptions of coverage. For certain types of insurance coverage, including fire and workers' compensation, a standard form is required. Other coverages, such as life and health, forbid the use of gimmickry in their forms and verbiage.

The commissioner, upon reviewing a new policy format, may overrule any type of wording in provisions that may be deceptive or misrepresent the "real" coverage. The unfortunate aspect of this particular type of regulation is that most state insurance departments have neither the funds nor the trained personnel to review every form that is used for insuring individuals in that state.

Regulation of Business Methods

In an effort to protect the public from possible dishonesty and deceptive practices, the states regulate business methods by licensure of agents, by issuing surplus-line licenses for agents doing business for non-admitted insurers, and by policing the industry for activities such as misrepresentation of facts, rebating, and practices such as twisting.

When a state issues a license to agents to do business in that particular state, the agent must meet certain qualifications, and, in a growing number of states, a written examination must be passed to receive a license. Some states require agents to complete and pass a curriculum of courses before taking an examination. But, in some states, no written examination is required because those states assume that an agent who will successfully sell insurance is equipped to do so. However, in these states, completion of an insurance training course is usually required.

In most states, licenses are issued for one year and automatically renewed. In some states, continuing education courses are required for renewal, and a few states may require the completion of credit courses. Some license renewals may be disapproved or revoked, but this is done only if the state commission can prove dishonesty.

In a few states, only resident agents of that state are licensed, usually to protect the "local" businesses from competition; however, other states require property and liability insurance contracts to be signed by a local agent before they can go into force.

In some instances, the resident agent receives a portion of the commission, from 30 percent to 50 percent. This practice has been a bone of contention with some members of the NAIC, but there have been no laws passed to discontinue the practice of resident agent featherbedding.

There are state laws that prohibit any business from misrepresenting its services or duping the purchaser, but in the insurance industry, some "twisting" does still occur, particularly in the life insurance industry. Some agents are so intimidated by this rule that they will not make valid suggestions for changing coverages.

As mentioned before, a blatant violation committed by some insurance agents is that of "rebating" or offering to pay a customer a refund of part of the commission. This practice violates the anti-rebating laws on the books in every state in this country. The laws initially were put into place to protect competition and to protect honest agents from the make-a-fast-buck and unreliable variety. Some of the anti-rebating laws prohibit the agent from providing any favor or other consideration that would be construed as a "come-on" to purchase a certain policy.

In the insurance industry, there are "exposures"—those policies that "expose" the company to the possibility of a loss. Some exposures are adjudged better than others, and it is important to make the distinction between an "exposure" and an "unfair exposure"—which is an exposure that places the business in jeopardy.

In some states, some companies and/or agents have attempted to provide customers with lower insurance rates than others. This is prohibited by state laws, and this type of "unfair exposure" is deleterious to fair competition among the many insurance companies doing business in each state.

It should be emphasized that the business methods and practices of most insurance firms are reputable and entirely within the law; however, because of past infractions and questionable trade practices, more regulatory efforts have been put into place to discourage further use of those methods of doing business that are found to be against the public interest.

State vs Federal Regulations

Arguments surrounding the debate of state vs. federal regulations have continued for the better part of two centuries, with flames intensifying around controversies regarding state control and the regulation of issuance rates. During former President Jimmy Carter's term of office, a national regulatory commission was named for the purpose of reviewing the implications of antitrust laws, particularly the McCarran Act, which provides certain antitrust immunity for the insurance industry.

Which type of regulation is preferable—state or federal? This question, too, remains at the forefront of the ongoing debate. However, experts such as Kimball and others believe that such a question does not embrace the complexity of the regulatory bodies. According to Kimball, the question is not which is better for regulation—state or federal—but what combination of these two entities would be preferred, for he concedes that neither one can be applied without the other. What Kimball does suggest is that the two be considered separately, with an examination of their advantages and disadvantages.

The Advantages of Federal Control

Between the rulings of Paul vs. Virginia and the South-Eastern Underwriters Association, hundreds of briefs have been filed against state regulation and in favor of the insurance industry being considered commerce. However, those who were in favor of federal control of the insurance industry took this stand because they believed it would be less complex.

Even today, because of issues surrounding rate regulation, those favoring federal control continue to make their voices heard. Their reasons for favoring a move from state to federal regulatory control often are seeded by their frustration with state regulatory boards, but they also contend that federal regulation would be to the advantage of the entire industry. Some of their arguments include:

Insurance is a product sold and used throughout the nation. Because of this national scope, it logically follows that the industry should be regulated by a federal body.

Each state has its own laws and regulations regarding the insurance industry (and others, as well). By placing the insurance industry under federal regulation, insurers would be able to comply with a uniform system of regulation.

Total federal control over the industry would avoid the "overlapping" regulations that often occur in the state-federal regulatory environment.

Because the industry is currently regulated by 52 separate departments (50 states, plus the District of Columbia and Puerto Rico), it seems logical to assume that these 52 departments are more costly to operate than one centralized federal department.

Federal regulation would be more competent, and this would be assured by the election of one department head, as opposed to 52 state commissioners. Further, the Congressional body, which has longer terms (because it is full-time) than state legislatures, allows its members more time to study and become versed in the various issues that may confront the industry.

The Disadvantages of Federal Control

In spite of its legions of proponents, federal control advantages are sometimes illusory, and they would ultimately pose as many problems as the complexities of 52 separate offices. The following comprises a partial listing of the disadvantages of federal control:

Because of the vastness of the U.S. insurance industry, regional offices would be put into place, providing at least as many approaches to the regulation of insurance in each region. Compliance would be inconsistent at best and irregularly enforced, simply because of the scope of the regulatory areas.

Because of the nature of the federal bureaucracy, other regulatory bodies would become involved in the regulation of the insurance industry. This would result in overlapping regulations, more complexity, more confusion, and, bottom line, more problems for both the industry and the consumer.

Many of those Washington bureaucrats charged with regulatory responsibilities are not always well-versed in the various areas they manipulate. Therefore, it is probable that these same individuals would be charged with regulating the industry without adequate information or experience.

The Advantages of State Regulation

As with the backers of federal regulation, those favoring state regulation of the insurance industry have also advanced some specific arguments over the years. The following represents a sampling of these theories:

State regulation is a familiar experience. There are few unknowns involved within the process. Many in the industry believe that it would be far more advantageous to examine current practices and build on the experience of existing regulatory measures than to begin with a totally unknown system.

Because state offices would be more familiar with the local environment, many believe it would be more effective to have the individual states rule on issues, as opposed to a centralized federal department of regulation.

Because the state departments have the ability to deal with problems more efficiently than a centralized federal agency, it follows that a decentralized regulatory system is more effective than one that is centralized.

Federal control could prove to be a factor that would "level" the quality and effectiveness of regulation, discouraging and/or weakening those state systems that are superior to others.

While federal regulation may, at times, be arbitrary, the proximity of state regulatory bodies makes communications between the regulator and the insurgent easier.

Currently, if a state errs in its handling of certain problems, the surrounding states are not enveloped in the ripple effect that would occur if federal regulatory errors were made.

Which Is Better?

After reading the previously stated arguments for federal and state regulation, it depends on one's individual biases as to which arguments appear to be more appropriate for the regulation of an entire industry.

The points made for federal control continue to emphasize uniformity and effectiveness. In the case of uniformity, a single federal agency would replace 52 separate entities (50 states, plus the District of Columbia and Puerto Rico). The idea of a single set of regulations, as opposed to 52 sets for those insurance companies operating throughout the U.S., is extremely appealing.

The other popular point—that of effectiveness—is also appealing because it would be funded to operate on a more expansive level than most state departments.

In arguments supporting total state regulation of the insurance industry, supporters hold up "flexibility" and "workability" as the primary reasons for change. They also argue that a state insurance department would be more aware of local needs than a federal entity and better able to respond quickly to changing trends. Because state regulatory systems are in place at the moment, proponents say that they are better tested and, therefore, able to provide better services because of the existing track record.

Replacing the existing system with an untested federal program may, in the final analysis, produce a system that is less effective and less responsive to the needs of the insurer and those of the insured. Whether or not this argument is viable depends on the current efficiency of any state insurance department.

It is important to remember that the public interest must be of primary concern when evaluating the "pros" and "cons" of one regulatory system as opposed to another. The argument as to whether state or federal regulation is best continues to move from one side of the debate to the other. As to the outcome of this controversy, it would be fair to conjecture that the debate will continue for several more decades.

Taxes

Like any other industry, insurance companies in America pay local, state, and federal taxes and fees. The bulk of these taxes are levied by the state; however, some communities and municipalities collect taxes as well. These mandatory payments include income taxes, property taxes, license and filing fees for annual financial statements, and fees for taking the insurance licensing exam. Companies also pay taxes on franchises (if they apply), premium taxes (although some states tax insurance companies as an alternative to premium taxes), and special taxes on workers' compensation and various other types of insurance.

Applicable Rates and Rules

While state taxation varies according to state requirements, income taxes are levied according to formulas found in the Income Tax Code, and taxation on real estate and property are the same as for any other taxpayer. In some states, taxes levied on fire insurance premiums go to support local fire departments. Likewise, the taxes on workers' compensation insurance are used to establish the system, security funds, and funds to underwrite programs for employing individuals with disabilities.

One of the most unique—and most controversial—of taxes paid by insurance companies is the premium tax. At one time, the proceeds from this form of taxation were used to pay the costs of regulation; however, state insurance companies today receive only a small portion of the premium tax, with the greater part of the proceeds used to fund other services provided by the state. This particular tax has brought an outcry from the insurance industry, with objections centering around the seeming inequity in taxing one industry without taxing others. The bottom line of the premium tax is that it is ultimately paid by insurance subscribers, and no state has reported any problems in collecting the premium tax.

The truth of the matter is that the premium tax is a bone of contention within the industry. First of all, the states vary taxation rates between 1.7 percent and 4 percent, with 2 percent being the most widely used. In some states, U.S. companies are taxed at a lower rate than foreign companies, a situation that the NAIC has worked to eliminate.

To strike some type of balance, a large majority of the states charge what is called a retaliatory tax, which equalizes the domestic tax rate for companies operating outside the state.

In some states, too, the premium tax varies, according to the line of insurance, based on whether or not the insurance company may have some of its assets invested in that state. The states also vary their formulas for calculating the premium tax. In some cases, the insurance company is allowed to deduct its policy dividends from its tax base, but few states allow this deduction. According to reports from the various state insurance departments, a majority of the states say that their premium tax is levied in place of other taxes. Other states report that they allow insurers to offset the premium tax with the payment of other taxes.

Because the methods of taxation vary, there are definite inequities. This occurs when individuals purchasing personal life or health insurance in some low-premium tax states are asked to pay premiums equal to those charged in high-premium tax states.

Today, some states are considering an income tax in place of a premium tax (or, in some instances, in addition to the premium tax). The difficulty in determining a company's income is most often cited as a reason for not going forward with this idea. It is also important to know that most states have different formulas to measure income.

Pricing of Insurance Rates

Although most insurance rates are the result of extremely complicated formulas, a simplified explanation is this: insurance rates are a determination of a policyholder's percentage of responsibility for loss expenses. The premium to insure the property—usually home or automobile—is the rate per unit of coverage multiplied by the number of units purchased.

Here are some examples: Say you want to purchase a homeowner's policy. A unit would be 100 square feet within the building. If you want to purchase life insurance, the unit may be $100 or $1,000 of coverage purchased.

Once the cost per unit is established, the insurer must look into the future to determine the percentage chance that the homeowner will suffer a loss, based on past experience and the rate of probability that a homeowner will file a claim. This historical experience, plus the influence of new trends and developments (such as improved building materials), are also taken into consideration to determine the final rate to be paid.

Historically, insurers calculated each policy on a separate basis. But, as business increased, this system proved to be too cumbersome, and insurance companies also found some glaring deficiencies in their existing methods. Rate setting (or making) soon became a group effort in order to make rates both profitable for the companies and fair to the policy buyers.

These rates were published, and if variances were appropriate, the established rates became the basing point for these variations. The various lines of insurance began setting their own rates, and today, the industry trends suggest that independent rate making is the rule for all types of insurance coverage.

Rate Regulation Objectives

When a rate filing is submitted to the state insurance department by an insurance company, the data submitted is evaluated by the department, with three objectives in mind:

- To prohibit excessive rates for coverage.
- To maintain the financial solvency of the company.
- To avoid unfair discriminatory rates.

The strictness and meticulousness with which new rates are evaluated depend on the state. In some states, for example, property and casualty rates require explicit approval by the insurance commission prior to the use of new rates. In other states, the "open competition" condition exists, and it is assumed that the competition will regulate costs much more effectively than the insurance commission.

In the "open competition" states, the commissioner of insurance may curtail the use of certain rates, particularly those violating rating standards, but rates do not have to be filed and approved, as is the practice in the more rigidly controlled states.

It is worth noting here that anyone who has a grievance against an insurance agent or insurance company is invited to file a complaint and is entitled to a hearing. However, the burden of proof that rate filings do, indeed, comply with the law is on the shoulders of the insurance company or the rating bureau.

Life insurance rates are not regulated in the same manner as other coverages are regulated. The control of these rates is indirect, or, in other words, based on the supervision of mortality tables, dividends, and interest rates used to compute the reserves of life insurers. When these controls are combined, the result is an indirect regulation of life insurance rates that are inadequate, excessive, or discriminatory.

Within the regulation of life insurance discussion, there is one central controversy, and this centers around "cost disclosure." This is because life insurance rates do not reflect the true costs of the policy to the company. Therefore, a policy having a low premium may be very costly to the issuing insurer, or the opposite may be true— a policy with a high premium may require very little from the insurer, cost-wise.

To provide consumers with a better understanding of life insurance rates, and to give them a better tool with which to compare the costs of various policies and coverages, the industry has turned to the interest-adjusted method for computing policy costs. Indeed, the NAIC has suggested that the states require life insurance companies to provide detailed information to consumers about the costs of a policy. Some states have agreed to this suggestion. Others vehemently oppose this method. Ultimately, some consumers have agreed, saying that the interest-adjusted computation is just as difficult to understand as other methods, and that they will rely on their agents for guidance in purchasing adequate coverages for their individual needs.

Who Decides on the Regulations?

In terms of regulating rates, the state insurance commissioner decides whether or not to approve a rate. In some states, the commissioner is assisted by appointive rating organizations to collect and maintain data regarding rates. The commissioner also has access to rating laws that involve the technical requirements of methods for recording/reporting losses and expenses over certain periods, as well as the exchange of rating plan data and the experience and advice of other states.

Rates for life insurance lines are regulated individually by guidelines applicable to the insurer's reserves and the liability of these reserves. However, the reserve requirements do not relate to the premium charged. As an example, if the insurance company charges a premium on a life insurance policy that is inadequate to cover its exposure, the company's assets will soon be smaller than the liability of the coverage it will have to eventually pay.

The thinking among insurance industry leadership and regulators alike has been that competition would ward off non-excessive rates, but because the consumer public has neither the technical knowledge nor general understanding of the industry, it is questionable that competition serves as an effective regulator of life insurance.

To serve as a guide for charging rates, the industry has developed price indexes based on formulas developed within the industry. The indices are used by a large number of companies. The states have also entered into the educational area of the industry by publishing buyers' guides showing the prices of a number of life insurance lines.

In the case of health insurance lines, there are several states that require these lines to file a schedule of their rates with the insurance commissioner. Other states allow the commissioner the ability to disapprove health insurance forms, particularly if benefits and premiums are not proportionally balanced.

Some states require that insurers file a listing of expected losses associated with the claims filed on health insurance. In addition, all states require that insurance companies file reports of their loss ratios. While the public interest automatically requires scrutiny of each case in point, the states cannot provide enough professionals to review or supervise health insurance. In fact, so many different health insurance policies now exist that it is impossible to check their rates against benefits. In some cases, the rates are controlled.

Rating Methods/Systems

Early in this century, insurance companies were confronted by a major problem—that of controlling rate levels for fire insurance. After a series of less effective solutions were tried, the companies found that by banding together and determining the rates they would charge, they found that not only did the profits increase, but fewer bankruptcies occurred.

Calling themselves rating bureaus, the companies that joined together soon faced opposition from the states. The contention was that these cooperative pricing groups may be against the best interests of the consumer in the long run.

To take a closer look at the situation, the New York Legislature established a study of the industry by a body called the Merritt Commission in 1911. This commission was charged to investigate the rating bureaus and then to publish its findings. After a lengthy review of the bureaus, the Merritt Commission reported that the establishment of rates by the rating bureaus was the best approach to controlling fire insurance rates. The rates established were based on the joint experiences of the bureau members and would be more reliable than any other method.

The commission determined that the rating bureaus would be allowed to function legally in New York, and in exchange for this privilege, the state would ultimately approve the rates. After delivering their report, the Merritt Commission's plan was readily approved, and more states followed its lead. This established a precedent for the industry and also for the involvement of the state in the regulation of rates for the industry.

As new demands for various coverages arose, the pattern of companies joining together to form rate bureaus continued. As the insurance industry grew larger, the rate bureau system of regulation gained both momentum and support from the state insurance departments. The underlying energy for this support was the belief that price competition among insurance companies would eventually weaken the industry—a situation that would be less than advantageous for the public interest.

Insurance Rate Classification Systems

In recent years, the legitimacy of some types of insurance rate classification systems has been questioned. Rates such as automobile insurance rates are usually based on factors such as the age, sex, and marital status of the driver, the type of vehicle, the place where the vehicle is usually parked, and other factors. Discounts are often provided for young drivers with good driving records, those who get good grades, and drivers who have taken defensive driving courses.

Generally, insurers maintain databases with statistics for losses on the basis of these types of classification systems and, by using these statistics, determine the insurance rates for each factor within the classification. Through the use of these records, for example, insurers believe that drivers under age 20 are involved in 18.1 percent of all accidents, in spite of the fact that this age group represents only about 10 percent of the drivers. Therefore, on the basis of this classification system, drivers in this age category are charged more than drivers of older age groups. Males pay more for their insurance than females, and drivers with newer automobiles usually pay more than those with older vehicles.

Because young, single males pay some of the highest automobile insurance rates, they have raised objections to the classification system currently in use. Three states—Hawaii, Massachusetts, and North Carolina—do not allow insurers to use these classifications, and therefore, have reduced the premiums for young male drivers.

In another example of the current statistics, the color of the automobile is significant to the amount of exposure to the insurer. Light-colored automobiles are less likely to be in an accident than dark-colored automobiles, presumably because the light-colored car may be more easily seen. Similarly, data indicates that four-door vehicles are less accident-prone than two-door vehicles, even in the same make and model category. However, automobile insurers do not take these statistics into account when setting insurance rates for a particular driver. Instead, they look at age, sex, and other factors.

More recently, in the life insurance industry, a classification problem has arisen involving the use of the insured person's sex as a rating factor. Generally, women have lived longer than men in the United States, and therefore, women pay lower premiums for life insurance and higher amounts for annuities. In 1978, the Supreme Court ruled that the City of Los Angeles Department of Water and Power could not require women to contribute more than men into an employer-controlled pension fund. Because of the Equal Pay Act of 1963, the court ruled that the Department of Water and Power was violating the act by asking women to contribute more.