1. The Life and Health Insurance

After reading this chapter, you should be able to

- Distinguish among the three types of business organizations and explain why insurance companies must be organized as corporations

- Identify how stock insurers differ from mutual insurers

- Describe the financial services industry and how insurance companies function within that industry

- Identify the major type of life and health insurance products

Insurance Companies as Business Organization

- A *business* can be defined as an organization established for the propose of producing goods ro services, typically for a profit.
- *Profit* is the money, or revenue, that a business receives for its products or services.
- Each business organization is structured in one of three ways:
  - As a sole proprietorship, it is owned and operated by one individual. The owner reaps all profits and is personally responsible for all the debts of business. If the business fails, the owner's personal property may be used to pay the debts of the business. If the owner becomes disabled or dies, the business usually closes its doors.
  - As a partnership, it is a business that is owned by two or more people, who are known as the partners. The partners reap the profits and are personally responsible for the debts of the business . If one of the partners dies or withdraws from the business, the partnership generally dissolves, although the remaining partners may form a new partnership
  - As a corporation.

A *corporation* is a legal entity that is created by the authority of a governmental unit and that is separate and distinct from the people who own it. A corporation has two major characteristics that set it apart from a sole proprietorship and a partnership.

1. A corporation is a legal entity that is separate from its owners. As a result, a corporation can sue or be sued, can enter into contracts, and can own property. The corporations's debts and liabilities belong to the corporation itself, not to its owners. The owners are not personally responsible for the corporation's debts.

2. The corporation continues beyond the death of any or all of its owners. This characteristic of the corporation provides an element of stability and permanence that a sole proprietorship and partnership cannot guarantee.

The stability makes the corporation the ideal form of business organization for an insurance company. Because insurance companies must be permanent and stable organizations, laws in the United States and Canada require insurance companies to operate as corporations

Types of Insurance Company Organizations

Even though they must be corporations, life and health insurance companies have some flexibility in how they are organized to do business. Typically, however, insurers are organized as either stock companies or mutual companies

- **Stock Insurance Companies**
  A *stock insurance company* is an insurance company that is owned by the people and organizations that purchase shares of the company's stock. From time to time, a portion of the company's operating profits may be distributed to these stockholders in the form of *stockholder dividends*.

- **Mutual Insurance Companies**
  A *mutual insurance company* is an insurance company that is owned by its policyowners, and a portion of the company's operating profits are from time to time distributed to these policyowners in the form of *policy dividends*.

Before a mutual company can be formed, a certain number of policies must be sold in advance to provide the funds the company needs to begin operations. Because most people are reluctant to purchase product from a company that does not yet exist, most mutual companies in existence today began many years ago as stock companies and later converted to mutual companies. This process of converting from a stock company to a mutual company is called *mutualization* . One advantage that *a stock company gains from the process of mutualization is that a mutual company cannot be bought by another company since a mutual company has no stock to sell*.

During the later 1990s, a number of U.S. and Canadian mutual companies reorganized as stock companies through the process of *demutualization*. The primary reason a mutual insurer might wish to demutualize is that, as a stock company, it can more easily raise operating funds because it can issue additional shares of stock to public. Stock insurers also have greater flexibility than mutual insurers in buying and operating other types of companies.

Insurance Companies as Financial Intermediaries

Insurance companies are financial intermediaries that function in the economy as part of the financial services industry

- A *financial intermediary* is an organization that helps to channel funds through an economy by accepting the surplus money of savers and supplying that money to borrowers who pay the money.

- The *financial services industry* is made up of various kinds of financial intermediaries that help consumers and business organizations save, borrow, invest, and otherwise manage money.

- Life and health insurance companies invest their assets in other business and industries, as well as in mortgage loans. These investments help provide the funds that other businesses need to operate and grow ant that individuals need to purchase homes.

Overview of Life and Health Insurance

Life and health insurance companies market a variety of insurance and investment-type products.

Individual and Group Insurance

Life and health insurance companies market insurance products to both individuals and groups.

- An *individual insurance policy* is an insurance policy that is issued to insure the life or health of a named person.
  Some individual policies also insure the person's immediate family or a second named person.

- A *group insurance policy* is a policy issued by an insurance company to a party that is purchasing insurance coverage for a specific group people.
  For example, a group insurance policy is usually purchased by an employer to provide life and health insurance coverage to its employees and, sometimes, to the dependents of covered employees.

Life Insurance

A *life insurance policy* is a policy under which the insurance company promises to pay a benefit upon the death of the person who is insured. Life insurance is provided on both an individual and a group basis and is available under a variety of types of policies.

- **Term life insurance** provides a death benefit if the insured dies during a specified period.
- **Permanent life insurance** provides life insurance coverage throughout the insured's lifetime and also provides a savings element. As premiums are paid for these policies, an accumulated savings amount–known as the policy's cash value–gradually builds.
- **Endowment insurance** provide a policy benefit that is paid either when the insured dies or on a stated data if the insured lives until then . Endowment insurance has some characteristics of both term life insurance and permanent life insurance.

In each case, the policy benefit is paid only if the policy is in force when a covered loss occurs.

Annuities and Investment Products

In addition to providing life insurance coverage, life insurance companies market various products that are designed to provide consumers with a way to provide themselves with periodic income benefits, especially retirement income benefits.

An *annuity* is a series of periodic payments. For example, when the insured of a life insurance policy dies, a relatively large sum of money is often payable. Life insurance policy proceeds can be paid in form of an annuity, over a period of time, rather than in a lump sum. An annuity can also be a contract under which an insurance company promises to make a series of periodic payments to a named individual in exchange for a premium or a series premiums.

Health Insurance

A *health insurance policy* is a policy that provide protection against the risk of financial loss resulting from the insured person's sickness., accidental injury, or disability. The two major forms of health insurance coverage are as follows:

1. *Medical expense coverage* provides benefits to pay for the treatment of an insured's illness and injuries.

2. *Disability income coverage* provides income replacement benefits to an insured who is unable to work because of sickness or injury.

Health insurance coverage is available to both individuals and groups and is provide by a variety of organizations and governmental programs in addition to being providing by commercial life and health insurance companies.

Other Providers of Life and Health insurance

Most of the discussion in this text will relate to commercial life and health insurance companies. By what we mean corperations taht are organized as stock or mutual insurance companies to provide life and/or health insurance coverages. But, in addition to insurance companies, an array of other organizations–public and private–provide life and health insurance.

Fraternal Benefit Societies

A *fractional benefit society* is an organization formed to provide social, as well as insurance, benefits to its members. The members of such societies often share a common ethnic, religious, or vocational background, although membership in some societies is open to the general public. One of the legal requirements of being a fraternal benefit society is that the fraternal must have a representative form of government—the members must select the officers of the fraternal society. Additionally, fraternals must operate through a lodge system whereby only lodge members and their families are permitted to own the fraternal society's insurance. In fact, applicants for insurance often become a members of the society automatically once the society issues them a policy.

- **Banks** Most people do not think of banks as being providers of insurance. In certain instances, however, banks in the United States or Hong Kong can sell insurance products

- **Government** For example, federal, state and provincial programs provide various health insurance and retirement income coverages to residents of the United States and Canada.

- **Medical Care Plan** Various types of medical care plans provide health care benefits to individuals or groups either by (1) assuming coverage for insured s in exchange for a premium or (2) providing health care services on a prepaid basis. For example, *Blue Cross and Blue Shield plans* provide various medical expense coverages in exchange for the payment of premiums. A *health maintenance organization (HMO)* is an example of a health care organization that provides prepaid medical care services to its members.

2. Introduction to Risk and Insurance

All insurance provides protection against some of the economic consequences of loss. Thus, insurance meets part of individuals' and business need for economic security. The underlying purpose of insurance products: To provide protection against the risk of financial loss. In order to understand insurance.

The concept of Risk

- **Speculative Risk** It involves three possible outcomes: loss, gain, or no change. For example, when you purchase shares of stock, you are speculating that the value of the stock will rise and that you will earn a profit on your investment. At the same time you know that the value of stock could fall and that you could lose some or all of the money you invested. Finally, you know that the value of the stock could remain the same—you might not lose money, but you might not make a profit.

- **Pure Risk** It involves no possibility of gain; either a loss occurs or no loss occurs. An example of pure risk is the possibility that you may become disabled. If you are unable to work, you will experience a financial loss. If, on the other hand, you never become disable, then you will incur no loss from that risk.

Risk Management

- **Avoiding Risk**

  The first, and perhaps most obvious, method of managing risk is simply to avoid risk altogether. We can avoid the risk of personal injury that may result from an airplane crash by not riding in an airplane, and we can avoid the risk of financial loss in the stock market by not investing in it. Sometimes, however, avoiding risk is not effective or practical.

- **Controlling Risk**

  We can try to control risk by taking steps to prevent or reduce losses. For instance, store owners could reduce the likelihood of a fir in their store by banning smoking in their building and not storing boxes or paper near the building. The store owners could install smoke detectors and a sprinkler system in their building to lessen the extent of damage likely to result from a fire.

- **Accepting Risk**

  A third method of managing risk is to accept, or retain, risk. Simply stated, to accept a risk is to assume all financial responsibility for that risk. Sometimes, as in the case of an insignificant risk—losing an umbrella— the financial loss is not great enough to warrant much concern.

- **Transferring Risk**

  It is a fourth method of risk management. When you transfer risk to another party, you are shifting the financial responsibility for that risk to the other party, generally in exchange for a fee. The most common way for individuals, families and businesses to transfer risk is to purchase insurance coverage.

When an insurance company agrees to provide a person or a business with insurance coverage, the insurer issues an insurance policy. The ***policy*** is a written document that contains the terms of the agreement between the insurance company and the owner of the policy. The agreement is a legally enforceable contract under which the insurance company agrees to pay a certain amount of money — known as the ***policy benefit***, or the *policy proceeds*— when a specific loss occurs provided that the insurer has received a specified amount of money, called ***premium***.

In general, individuals and businesses can purchase insurance policies to cover three types of risk—property damage risk, liability risk, and personal risk.

Managing Personal Risk Through Insurance

If the economic losses that actually result from a given peril, such as disability, can be shared by large number of people who are all subject to the risk of such losses and the probability of loss is relatively small for each person, then the cost to each person will be relatively small.

Characteristics of Insurance Risks

1. The loss must occur by chance.
2. The loss must be definite.
3. The loss must be significant.
4. The loss rate must be predictable.
5. The loss must not be catastrophic to the insurer.

The Loss Must Occur by Chance

In order for a potential loss to be insurable, the element of chance must be present. The loss should be caused either by an unexpected event or by an event that is not intentionally caused by the person covered by the insurance. For example, people cannot generally control whether they will become seriously ill; as a result, insurers can against financial losses caused by the chance event that an insured person will become ill and incur medical expenses.

When this principle of loss is applied in its strictest sense to life insurance, an apparent problem arises: death is certain to occur. The timing of an individual's death, however, is usually out of the individual's control. Therefore, although the event being insured against — death — is a certain event rather than a chance event, the timing of that event usually occurs by chance.

The Loss Must be Definite

For most types of insurance, an insurable loss must be definite in term of *time* and *amount*. In other words, the insurer must be able to determine when to pay policy benefits and how much those benefits should be. Death, illness, disability, and old age are generally identifiable conditions. The amount of economic loss resulting from these conditions, however, can be subject to interpretation.

A ***contract of indemnity*** is an insurance policy under which the amount of the policy benefit payable for a covered loss is based on the actual amount of financial loss that results from the loss as, determined at the time of loss. The policy states that the amount of the benefit is equal to the amount of the covered financial loss or a maximum amount stated in the contract, whichever is less.

A ***valued contract*** specifies the amount of the benefit that will be payable when a covered loss occurs, regardless of the actual amount of the loss that was incurred. Most life insurance policies state the amount of the policy benefit that will be payable if the insured person dies while the policy is in force. The amount of the death benefit is called the policy's ***face amount*** or *face value* because this amount is generally listed on the face, or first, page of the policy.

The Loss Must be Significant

Insignificant losses, like the loss of an umbrella, are not normally insured. The administrative expense of paying benefits when a very small loss occurs would drive the cost for such insurance protection so high in relation to the amount of the potential loss that most people would find the protection unaffordable.

On the other hand, some losses would cause financial hardship to most people and are considered to be insurable. For example, a person injured in an accident may lose a significant amount of income if he is unable to work. Insurance coverage is available to protect against such a potential loss.

The Loss Must be Predictable

In order to provide a specific type of insurance coverage, an insurer must be able to predict the probable rate of loss— the *loss rate*— that the people insured by the coverage will experience. No one can predict the losses that a specific person will experience. We do not know when a specific person will die, become disabled, or need hospitalization. However insurers can predict with a fairly high degree of accuracy the number of people in a given large group who will die or become disable or need hospitalization during a given period of time.

An important concept that helps assure us of accuracy of our predictions about the probability of an event occurring is the law of large numbers.

The law of large number states that, typically, the more times we observe a particular event, the more likely it is that our observed results will approximate the "true" probability that the event will occur.

The Loss Must Not Be Catastrophic to the Insurer

A potential loss is not considered insurable if a single occurrence is likely to cause or contribute to catastrophic financial damage to the insurer. Such a loss is not insurable because the insurer could not responsibly promise to pay benefits for the loss. To prevent the possibility of catastrophic loss and ensure that losses occur independently of each other, insurers spread the risks they choose to insure.

Alternatively, an insurer can reduce the possibility that it will suffer catastrophic losses by transferring risks to another insurer. An insurer transfer risks to another insurer by reinsuring those risks. ***Reinsurance*** is insurance that one insurance company—known as the ***ceding company***—purchase from another insurance company—known as the ***reinsurer***—in order to transfer risks on insurance policies that the ceding company issued. To cede insurance business is to obtain reinsurance on that business by transferring all or part of the risk to a reinsurer. A life insurance company typically sets a maximum amount of insurance—known as its ***retention limit***— that the insurer is willing to carry at its own risk on any one life without transferring some of the risk to a reinsurer.

Insurability of Specific Risks

Insurance is sold on a case-by-case basis, and insurers consider a number of a factors in order to determine whether a proposed risk is an insurable risk.

Assessing the Degree of Risk

When an insurance company receives an application for insurance, the company must assess the degree of risk it will take on if it agrees to issue the policy. An insurance company cannot afford to presume that each proposed risk represents an average likelihood of loss. Not all individuals of the same sex and age have an equal likelihood of greater than average likelihood of loss tend to seek insurance protection to a greater extent than do those who believe they have an average or a less-than-average likelihood of loss. This tendency, which is called ***antiselection***, *adverse selection*, or *selection against the insurer*, is a primary reason that insurers need to carefully review each each application to assess properly the degree of risk the company will be assuming if it issues the requested policy.

The process of identifying and classifying the degree of risk represented by a proposed insured is called ***underwriting*** or *selection of risks*, and the insurance company employees who are responsible for evaluating proposed risk are called *underwriters*. Underwritting consists of two primary stages: (1) identifying the risks that proposed insured presents and (2) classifying the degree of risk that a proposed insured represents.

Identifying Risks

Insurers cannot predict when a specific individual will die, become injured, or suffer from an illness. Insurers, however, have identified a number of factors than can increase or decrease the likelihood that an individual will suffer a loss. The most important of these factors are physical hazards and moral hazards.

A ***physical hazard*** is a physical characteristic that may increase the likelihood of loss. For example, a person with a history heart attacks possesses a physical hazards that will increase the likelihood that the person will die soon than will a person of the same age and sex who does not have a similar medical history.

Moral hazard is the likelihood that a person may act dishonestly in the insurance transaction. For example, an individual with a confirmed record of illegal behavior is more likely to defraud an insurer than is a person with no such record, and an insurer must carefully consider that fact when evaluating such an individual's application for insurance.

Classifying Risks

After identifying the risks presented by a proposed insured, the underwriter can classify the proposed insured into an appropriate risk category. The purpose of classifying risks into categories is to enable the insurer to determine the equitable premium rate to charge different premium rates. Without these premium rate variations, some policyowners would be charged too much for their coverage, while others would be paying less than the actual cost of their coverage.

In order to classify proposed insureds, underwriters apply general rules of risk section, known as ***underwriting guidelines***, established by the insurer. Underwriting guidelines generally identify at least three risk categories for proposed insureds: standard risks, substandard risks, and declined risks. Many insurance companies' underwritting guidelines include a fourth risk category: preferred risks.

- Proposed insured who have a likelihood of loss that is not significantly greater than average are classified as ***standard risks***, and the premium rates they are charged are called standard premium rates. Traditionally, most individual life and health insurance policies have been issued at standard premium rates.

- Those proposed insureds who have a significantly greater-than-average likelihood of loss but are still found to be insurable are classified as ***substandard risk*** or *special class risk* Insurance companies use serval methods to compensate for the additional risk presented by insureds who are classified as substandard risks. In individual life insurance, insurers typically charge substandard risks a higher-than-standard premium rate, called ***substandard premium rate*** or *special class rate*.

- The ***declined risk*** category consists of those proposed insureds who are considered to present a risk that is too great for the insurer to cover. Applicants for disability income insurance coverage are also placed into the declined risk category if the insurer believes that the coverage is not needed to cover any income loss that would result from a disability.

- Many life insurers classify proposed insureds who present a significantly less-than-average likelihood of loss as ***preferred risks*** and charge these preferred risks a lower-than-standard premium rate. Some life insurers also have established a super-preferred risk classification that includes people who present an even lower level of risk than those who are classified as preferred risks. Insurance company practices vary widely as to what qualifies a proposed insured as a preferred risk or a super-preferred risk. As one example, some insurers categorize their standard risk into two risk classifications based on their smoking habits. Insureds who otherwise present a standard risk and are nonsmokers are classified as preferred risks and are charged less-than-standard premium rates; insured who otherwise present a standard risk but who smoke are classified as standard risks and are charged standard premium rates.