

RMI STRAIGHT LINE

A NEWSLETTER FROM THE MICHIGAN INSURANCE HALL OF FAME

SPRING 2009

Welcome to *RMI Straight Line*.

Why "*Straight Line*"? We want to provide a forum for an open, unembellished, no-spin line of communication about the risk management and insurance issues of the day. And as insurance exposures are measured in lines or layers, we want to promote a clearer understanding of the exposures of the business of risk-taking. We hope you'll find the *RMI Straight Line* to be a stimulating and informative newsletter. We invite your comments, criticisms, opinions on the topics of the day, responses to other articles, and letters to the editor for publication in future editions. Please send your submissions to rmi@olivetcollege.edu.

Michael R. Hubbel
Editor

Michigan Insurance Hall of Fame Mission

The role of the Michigan Insurance Hall of Fame is to recognize individuals for excellence in leadership, service and contributions to improve the ability of the Michigan insurance industry to serve the public in the state of Michigan, and furthermore to support education, research, and technology that advances the understanding and public awareness and recognition of the economic role of the insurance and risk management business.



Feature Article by:

Charles A. McAlear, CPCU
Founder of McAlear Associates, a wholesale broker,
founder of the National Association of Professional
Surplus Lines Offices, Ltd., and author of *The
Foundering Ark: Insurance on the Rocks*

This Issue's Featured Article by Charles A. McAlear *Wolves in Sheep's Clothing*

The healthcare icon is again flashing on the national radar screen. Healthcare costs have continued to climb, through good times and bad, faster than inflation, for generations.

In the early twentieth century, the middle class paid for its health care directly as billed. By the nineteen thirties, they had turned to healthcare pre-payment plans to cope with higher prices. During World War II, corporations working at full capacity assumed the burden, along with the unions. But the ever-increasing costs of our unique healthcare system has proven too much, even for this potent combination. It is now proposed that the economic resources of the entire nation be used to pay the bills; but there is no assurance that even the largest economy in the world can support the healthcare system it has spawned.

If anyone within the health care business knows what is causing their costs to escalate, they are not volunteering the information. The trillions of dollars at stake assure that this is not simply an academic question. As befits an economy that plays marbles with billions of dollars every day, the landscape abounds in black boxes. Whether it is healthcare, AIG, or Citigroup, there comes a point where informed speakers just shrug their shoulders. The answers lie sealed away, locked in seamless boxes, to which no one will admit to having a key. Or they lie right before us, under our noses, in documents no more confusing than the average hospital bill.

The answer must be in plain sight. Whatever causes health care costs to rise significantly faster than inflation can be described, at least to a limited degree. The condition is unique to the United States. That is one characteristic. Comparable countries have not had the same problem.

These consistent increases in health care costs at rates higher than inflation did not start yesterday. Americans have been paying a surcharge on their medical bills for generations.

Those who are counting the profits generated by these increased costs would not want to see them be eliminated or reduced. Therefore, it safely can be assumed that some of the present proposals for health care reform will preserve the same factors that have facilitated the increases in the past.

What is unique to the United States, is in plain sight, has influenced the price of all aspects of health care over a period of fifty years or more, and is likely to be part of proposed health care reform packages? If this can be isolated, health care reformers can take steps to avoid incorporating it in future healthcare programs. Healthcare insurance comes immediately to mind. It has been part of the American scene for over 75 years.

Healthcare insurance had not been given much thought by nineteenth century insurance underwriters. Healthcare lacked some of the characteristics associated with insurable events. It did not fit the mold. Claims did not arise out of something "sudden and accidental," like a fire or a windstorm. A wound had to be cared for even if it were self-inflicted, a thought that would have offended 19th century underwriting sensibilities. The traditional insurance powers that were may have seen these problems as insurmountable. For whatever reason, they avoided the inherent conflicts by continuing to provide "accident" insurance only. **Healthcare "insurance" was not a product of the traditional insurance business of London and Hartford.**

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State Farm and other mutual insurance companies were organized by their prospective customers, those who possessed property exposed to loss from natural or human causes, who were seeking an economical way of sharing that risk. The success of the enterprise depended upon keeping the losses low, spending as few dollars as possible to pay claims. Stock insurance companies entered the field, looking to profit from the same business model. Low losses remained the key to success. Among both stock and mutual insurers, regardless of the subject of insurance, the ultimate success of the enterprise depended upon loss control.

It soon became clear that there was a tendency to inflate losses even among the most loyal of insured clients. In the past, economic transactions had commonly taken place at markets, where buyer and seller meet. Each can respond to changing conditions, matching changes in price, for example, to variations in quality. Negotiations are directly between buyer and seller and are wrapped up within a short time.

Insurance is different. Payment of the premium takes place in one time frame, while the payment for the loss takes place in a later period. The normal safeguards in a more traditional transaction do not exist. "Delivery of the goods" is delayed, and they may be conveyed to persons other than those who paid the premium. The almost universal tendency is for the client as claimant to demand more than is equitable. The tendency is so strong that some insurance is sold on a "new for old," or "replacement cost" basis to avoid extensive haggling.

If this tendency became a trend, it had the potential of destroying the entire insurance company business plan. Mutual insurance company founders did not start insurance companies to milk profits from their insured neighbors. Insurance companies, both mutual and stock, responded by employing aggressive claim adjusters who would pressure claimants to accept equitable settlements rather than the inflated ones they would have preferred.

The public came to understand and respect this aspect of the insurance business. They came to realize that an increase in the cost of claims was inevitably followed by an increase in their own premiums. They looked to insurers to find the lowest costs and trusted them to do so. A body shop favored by State Farm, for example, is likely to attract more business throughout the community, than one which is not so distinguished.

There was not an overwhelming demand for healthcare insurance in the 1920s. What did exist and was becoming more critical as the Great Depression loomed, was the economic plight of health care professionals. Medical services began to cost more than could easily be absorbed into a contemporary middle-class budget. Collections suffered as the payment of medical bills were often deferred. Hospitals began to suffer and so did individual doctors.

Leaders of the health care business searched for ways of getting paid for their services. They decided to sell "prepaid hospital plans." Those who signed up and paid the fees were entitled to a stay in a participating hospital.

Here, it is critical to note that these healthcare interests did not form insurance companies. Prepaid hospital plans were marketed by non-profit organizations founded by hospitals.

They were working to see the bills for their own services were paid regularly. **These organizations were not insurers started by potential clients of hospitals seeking lower costs. The hospitals were creating consumer finance arms to increase their profits or reduce their losses.**

There has never been any effort made to conceal this fact. For many years these entities loudly proclaimed that they were **not** insurance companies. In fact, as they claimed, they were in business to finance health care, just as GMAC was in business to finance the sale of GM automobiles.

If GM wanted to increase to the price of an automobile, it did not consult with GMAC. As their finance arm it was one of its functions to ease the immediate impact of price increases on consumers. Except for the "discounts" that helped make the plans popular, it is not likely that the fledgling providers of "pre-paid hospital plans" even considered influencing the prices charged by their hospitals.

The question of whether these sellers of pre-paid plans were actually insurance companies was an argument that originated with state regulators. To regulators, the plan vendors took money in now and paid it out later. It looked like a duck...Maybe it acted like a duck. But that did not mean it really was a duck. While these payment plan vendors came to be regulated as insurance companies, they continued to act as they proclaimed they were acting, as purveyors of "prepaid hospital plans" Just because regulators decided to regulate them as insurers did not mean they changed their business plans.

Even if they could have thought independently of their owner hospitals, they could not have resisted price increases. The key to providing hospital healthcare coverage is having hospitals recognize your plan as a source of payment at the time of admission. This is an important selling point, along with the discounts they offered with the cooperation of the hospitals. The hospitals can withdraw that pre-approval at any time, always maintaining an upper hand in the relationship.

This also is one explanation of why competing insurers never "adjusted" claims any more aggressively than had become customary under the original pre-payment plans. If they had, they would have lost their "pre-approval" status and found themselves denied access to an inexhaustible source of cash flow. The organizations that came to be known as insurers and their followers in the business of healthcare finance were completely controlled by the vendors of the services they were "insuring."

The pre-paying or insuring of healthcare in the United States has had the impact of increasing annual costs at a higher rate than inflation. Any proposal to reform healthcare that includes "insurance" or similar features will undoubtedly have the same effect. ■

Healthcare Insurance is the Problem, not the Solution.

For generations, the American healthcare business has been successful in regularly raising their prices, unhampered by competition or bothered by regulation, "Whatever the market will bear," has been their philosophy. Finance companies posing as insurers have been their instruments. This suggests that experienced healthcare insurers, in any guise, are lousy candidates to be vehicles for national healthcare reform. The struggle to reduce health care costs has yet to begin.

Because the insurance transaction lacks some of the characteristics of more common economic exchanges, it has been abused in the past. Several large states have passed laws prohibiting an insurer of auto physical damage, for example, from owning a body shop. There are various kinds of mischief that can be caused by this combination. The body shop can submit inflated bills to the insurer who pays them without question and then files for increased rates the next year. In this model, the insurer always loses money while the body shop's profits are always increasing. Concurrently, insurance rates climb and additional dollars are leveraged out of consumers' pockets.

Even when such schemes are not in place, insurance transactions can tend to be inflationary. Losses from past years affect next year's rates. The data must be massaged to reflect the precise rate of inflation but pin point accuracy is impossible. Some rates inevitably over-compensate for inflation. Purveyors of pre-paid hospital plans respond in the same way to the same conditions. Without competition or effective regulation, the impact of inflation can consistently be overstated.

In reviewing the history of healthcare insurance, it can be seen that traditional insurance companies, late to the healthcare scene, were just as eager to allow healthcare vendors to set prices as were the members of the healthcare community itself, who were selling pre-paid plans. All that was required to turn an insurer into a compliant enabler was motivation and access to enormous cash flow provided that. Even without that motivation, a few changes in key personnel, like claim managers or actuaries, could change a conservative insurer into an eager vendor of healthcare financing. Such is the structure of the insurance beast.

Everyone who has seriously examined the problem of healthcare finance on a national level has agreed that one hundred percent participation is either essential or highly desirable. Those who propose that some form of "insurance" be part of the solution acknowledge that buying insurance would become mandatory. Mandating the purchase of insurance is not new. In the past, various states have enacted laws requiring that insurance be purchased and the experience is revealing.

Auto liability or no fault insurance has been virtually compulsory in most states for more than half a century. Yet at least 14% of the cars on the road nationwide are being operated without insurance. Moreover, "the figures skyrocket in low-income and minority city neighborhoods."¹ There numbers closer to fifty percent are common.

Those not insured for healthcare were "nearly 46 million Americans, or 18% of the population under the age of 65."² While the numbers have become slippery from passing through

the hands of too many political advocates, and they are changing for the worse daily, it is a lead pipe cinch that the scofflaw drivers and the healthcare uninsured represent the same people, living in the same places, under the same conditions.

The lack of easy access to health care inflicts the most pain upon that substantial and growing portion of Americans who are uninsured. They will resist buying healthcare insurance just as they already resist buying auto liability or no fault insurance. These citizens continue to view insurance as a symbol of a national economic life to which they are the uninvited.

Employees of large corporations and many public entities have enjoyed a right to the very same healthcare services for which the poorest of our citizens will be forced to pay substantial premiums. Or they could accept a subsidy which would go even further to reinforce their conviction that the poor and the unemployed of America are second-class citizens. Insurance is vulnerable to falling under the control of the vendors of insured goods and services and thus used to increase consumer costs and the sellers' profits. Insurance can also serve to further isolate a substantial and growing portion of the American population that is already disadvantaged.

Besides being awkward in the context of healthcare, and vulnerable to abuse, insurance, when it is not essential to transferring real risk, is expensive, increasing the costs of associated goods or services significantly. It is no coincidence that few workers said to have "healthcare insurance" are actually "insured." "In firms with 5,000 or more employees, 89 percent of workers were covered by self-insured arrangements in 2006..."³

Self-insurance (simply paying claims directly) doesn't begin to make financial sense until a group is big enough that its individual losses and total losses per year can be limited by the purchase of "excess" insurance or "reinsurance" at a reasonable price. The larger the group, the less this insurance expense, as losses begin to be contained within mathematically predictable limits. At that point "self insurance" can start to pay huge dividends over any insurance program. That is why 89% of the workers in large groups are not "insured." but covered under "self-insured" arrangements.

That is also why smaller groups can benefit from insurance and the existence of insurers who can combine the experience of many small groups to achieve predictable results. With a group the size of the population of the United States, the experience of the group is entirely predictable. There is no need for "insurance" at any level, for any purpose. (Should smaller individual states or regions become vehicles for healthcare financing, that market could be explored.)

If an "insurance" solution to healthcare financing has proven to be too expensive for corporate America, it is difficult to see how it could be anything but a boondoggle for the government of the United States. The fact that self-insurance has been the most successful response to the healthcare challenge also means that expertise in administering healthcare programs is not concentrated among a few insurers but exists among many competitive contractors that have been serving

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corporate and governmental America for decades. They have been successful in representing their client's interests, not those of healthcare vendors.

A national healthcare plan would be less costly and far more likely to be successful if it were administered as a benefit or a right rather than as some kind of an "insurance" program. Without "insurance" the problem of the "uninsured" disappears.

A basic reason for an insurance program is to distinguish between those who are insured within it. When an equitable rate for all Americans under an insurance program is published, it will be open to a reasonable attack because it contemplates coverage for citizens with pre-existing conditions and chronic illnesses. Those free of such illnesses or conditions can argue effectively that they deserve a separate and lower rate, or better yet, the right to comply with the mandatory insurance laws by purchasing private insurance. This argument will be hard to refute in the context of insurance in a democracy because the protestors will constitute a **majority** of the insured. Healthcare reformers will be busy enough without being trapped within the conceptual prison of "insurance." ■

(Endnotes)

¹ Devvy Kidd. "The carnage of Uninsured Motorists"

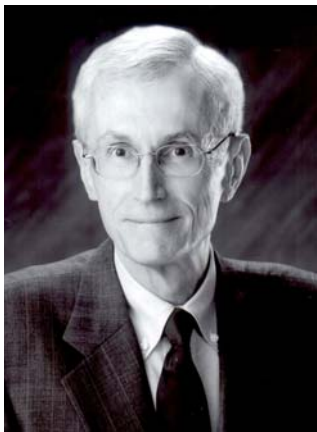
² National Health Care Coalition, "Facts on Health Insurance Coverage"

³ Employee Benefit Research Institute, EBRI Issue Brief No. 314, February 2008

Remarks upon Induction into the Michigan Insurance Hall of Fame

By Thomas C. Jones¹
September 17, 2008

Good evening. Larry, thank you for those kind words of introduction. It is a privilege to be here tonight and an honor to join the industry leaders who are members of the Michigan Insurance Hall of Fame. My thanks to the Board of Directors



Thomas C. Jones

of the Hall of Fame for selecting me to join this distinguished group. I would like to thank another group for making this recognition possible...the team within the Milliken administration that made regulatory innovation happen...people like Larry Owen, who served as my chief deputy; Mike Markman, who later served as Minnesota Commissioner; and our hard working and dedicated civil servants. I also had great support from two directors of the parent Department of Commerce, Dick Helmbrecht and Keith Molin. Governor Milliken also deserves special recognition for his leadership and support.

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I would like to thank another group for making this recognition possible...the team within the Milliken administration that made regulatory innovation happen...people like Larry Owen, who served as my chief deputy; Mike Markman, who later served as Minnesota Commissioner; and our hard working and dedicated civil servants. I also had great

This honor and the request for some brief remarks evoked reflection about both my time as Commissioner and my industry career. This reflection made me realize that my approach to regulation was fundamentally the same as the approach I subsequently applied to my work as an insurance executive.

Regulation, in my view, must be grounded in the unique and critical nature of the insurance business, the application of business analytical tools, and long-term strategic thinking.

Regulation is not a battle between insurance companies and consumers. It is not about ideology. It is not about regulation versus deregulation. It is about the most effective and efficient use of regulation and the competitive market to achieve economic objectives beneficial to the well-being of both the public and the insurance industry which serves that public. Insurance regulation should be a quest for the right balance between utilizing the power of a competitive market to improve product value and clear regulatory rules of the road to enable fair treatment and protection for companies, producers and consumers.

Given the critical role of the industry, the complexity of the products, the uncertainty of product costs, and the risk of funding future promises to pay, there needs to be a strong regulatory framework in four key areas:

1. Financial security and solvency (to protect the promise to pay),
2. Availability and choice (to make a competitive market viable),
3. Fair pricing, marketing, and distribution practices (to treat the same risks in the same way), and finally
4. Efficient economic value (to provide products with good value and fair profit margins).

It is critical not to underestimate the importance of the regulatory role in assuring the financial strength of insurance companies...to make sure they can honor their future promises to pay. While not visible to the public, I believe we accomplished a great deal by improve financial monitoring and working in new ways with individual companies undergoing financial stress.

As I reflect on our approach to the overall regulatory challenges we faced in each of these four areas, I believed we applied with varying degrees of success, the same business analytical tools, the same strategic thinking, and the same focus on long-term customer value that I have used so many times since as an industry executive.

To give a quick example of how we approached strategic issues, I will focus on our work with personal lines. Early in my tenure as Insurance Commissioner, I became concerned with the growing number of complaints concerning the availability of auto and homeowners insurance.

Our leadership team took a strategic and long-term approach to what we felt was a building availability crisis.

Our team researched the issues, met with industry and consumer groups, established clear objectives, analyzed alternative approaches, and developed a detail set of recommendations, which came to be known as Essential Insurance Reform.

The analysis led us to attempt to improve the pricing and availability of auto and homeowners insurance by first allowing the competitive market to set prices and earn profits without regulatory approval (which didn't make my liberal friends happy), to strengthen the standards governing the relative pricing of different classes of risks, to improve the process of assuring availability of coverage to all consumers (which didn't make my conservative friends happy), and to eliminate unnecessary bureaucracy (which as it turned-out made everyone happy).

I believe our report to the governor represented a thoughtful, fact driven and transparent attempt to deal with a growing problem and recommend a long-term strategic solution. The report produced a couple of years of legislative debate and I am proud to note, based on our recommendations, a comprehensive series of positive regulatory changes were approved after I left state government.

An amusing exchange with a wise, experienced, senior senator illustrates the difficulty of dealing with long-term issues. During a Senate Commerce Committee hearing, I, the thirty-year-old Commissioner was presenting our Essential Insurance report. I was making the case for taking action to avoid a potential crisis. Chairman Cooper interrupted and looked over his glasses to tell me, "Young man, you don't understand how government works. We don't have time to avoid a crisis. We only respond to a crisis." This was the beginning of my lifelong education in the challenge of focusing on the long-term I have often thought about Senator Cooper's insight as I have confronted private sector resistance to change.

I cannot conclude my reflections without a word or two about the current challenges facing the financial markets. I believe the current mortgage-initiated economic crisis is the outgrowth of a competitive market driven to excess as a result of inadequate regulatory safeguards to protect companies and consumers from fraud and reckless competition, an inconsistent set of capital requirements that are inadequate for the financial risks being taken, products so complex that only a math PhD. can even pretend to understand them, and an instantaneous and volatile global financial market.

The rescue of AIG is the latest example of the magnitude of these market forces and the failure of current regulatory safeguards. AIG lost their independence as a result of betting the company by diversifying into non-insurance financial products with risks they failed to understand.

As Senator Cooper would say, we have the crisis required to make change and to act. While I don't claim to have the long-term solution to this crisis, the answer is to find the right balance between a clear set of regulatory and capital requirements and a vigorously competitive market. I believe what we need is a truly bi-partisan blue ribbon commission to take a thoughtful, long-term view of the role of regulatory standards, capital requirements and competition in what is an increasing integrated set of global financial institutions.

Without a new set of regulatory and capital adequacy standards, enacted promptly by a bi-partisan congressional coalition, along with updated business models for financial companies, I fear a continuation or repeat of the current crisis.

Again, it has been an honor to be here tonight and to join the distinguished members of the Michigan Insurance Hall of Fame. Thank you. ■

(Endnotes)

¹ Thomas C. Jones was Commissioner of Insurance for the State of Michigan, 1975 to 1978, insurance executive with several major insurance firms, and is currently an active contributor to the University of Michigan and Northwestern Michigan College, and consultant to The Hagerty Group of Traverse City.

Risk Management & Insurance Center Master of Business Administration in Insurance

Olivet College is proud to announce the availability of a new graduate degree: the first live, online, professional MBA in Insurance where you can see and talk with your instructor! It has been accredited by the Higher Learning Commission – North Central Association. The new degree is designed for insurance professionals with or without an undergraduate degree in risk management or insurance.

Admission Requirements

To apply for the MBA program, applicants must:

- Have earned a 3.0 or higher (4.0 scale) overall grade point average in the applicants undergraduate degree
- Have an official 4-year undergraduate degree transcript mailed directly to the Olivet College Registrar from the granting institution
- Have at least 2 years professional experience in the field of insurance or risk management (*after* earning the undergraduate degree)
- Complete the Graduate Management Admissions Test (GMAT) earning a score of 500 or greater, and have official score sent directly to the Olivet College Admissions. You can go to www.mba.com/mba/thegmat for more information on the exam.
- Have letters of recommendation mailed directly from two professionals or academics who can comment on the applicant's abilities, talents, and aptitude for graduate study, to Olivet College Admissions
- Submit
 1. an application online to Olivet College Admissions
 2. a resume

Degree Requirements

A total of 48 credits must be completed within 7 years to earn the degree. Each course is 3 credit hours. Students must earn a 3.0 or higher grade point average to continue in the program and to graduate with the MBA degree.

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Required Courses

MBA 800 Insurance & Risk Management
MBA 808 Management & Organizational Behavior
MBA 809 Strategic Marketing
MBA 810 Managerial Economics
MBA 811 Corporate Accounting
MBA 812 Business & Insurance Law
MBA 820 Quantitative Analysis and Decision Making for Management
MBA 828 Managing a Diverse Workforce
MBA 830 Ethics & Leadership
MBA 835 Property-Casualty Insurance Contracts
MBA 840 Financial Management of Property-Casualty Insurers
MBA 890 Strategic Management of Property-Casualty Insurers

Electives offered as announced

MBA 802 Personal Financial Planning
MBA 803 Global Insurance & Risk Management
MBA 821 Advanced Spreadsheets & Databases
MBA 844 Reinsurance Principles & Practices
MBA 853 Employee Benefits
MBA 854 Risk Assessment
MBA 855 Risk Control
MBA 856 Risk Finance
MBA 863 Surplus Lines Insurance Operations
MBA 882 Variable Topics

Thesis Option

6 elective credits may be earned by completion of a thesis

Transfer Credits

- Maximum number of transfer credits accepted 24.
- Credit may be granted for some CPCU courses administered by the American Institute for CPCUs, IIA courses administered by the Insurance Institute of America (AIAF, ARe, ARM, ASLI), and CLU/ChFC courses administered by the American College. A list of Institute courses pre-approved for transfer will be available at <http://web.olivetcollege.edu/insurance> in the near future.
- *Official* transcripts from other educational institutions must be mailed directly to the Olivet College Registrar for review and acceptance of courses.

Delivery

Delivery of the classes will be via a blended online approach featuring live interactive video-audio streamed classes where students and faculty can see and talk to each other in real time, and the use of Blackboard software to post assignments, submit work, test, and participate in discussion threads. This will require access to broadband or DSL Internet connection, and a webcam, microphone and earphones. No required physical attendance at Olivet College. Four eight-week terms will be offered each year. The first year term dates will be posted at <http://web.olivetcollege.edu/insurance> in the near future. Each online class meeting is tentatively scheduled one day per week, 5:30 pm to 8:00 pm EST.

Questions?

You may contact the Risk Management and Insurance Center at Olivet College at insurance@olivetcollege.edu, (269) 749-7626, or by mail, 320 S. Main St., Olivet, Michigan 49076. We will post additional details as they are developed at our website: <http://web.olivetcollege.edu/insurance>. ■



The opinions expressed in this newsletter do not necessarily reflect the positions of Olivet College, Farm Bureau Insurance or the Michigan Insurance Hall of Fame.

Issues of *RMI Straight Line* will be also be available on our Web site at <http://web.olivetcollege.edu/insurance/>.

If you have questions or comments, please contact the Risk Management and Insurance Center at Olivet College by mail at 320 S. Main St., Olivet, Michigan 49076, by phone at (269) 749-7626 or via e-mail at rmi@olivetcollege.edu.