Dynamic Chiropractic

BILLING / FEES / INSURANCE

The Legacy of Insurance: Part I

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In the beginning insurance was a wonderful idea, giving hope and being an assurance of safety. The history of modern insurance goes back to the maritime laws codified in Rhodes in the 1st century, B.C., as protection from loss when cargo was jettisoned to save a ship threatened by storms; some elements of life insurance can be seen in practices of the ancient Greeks and Romans in religious societies which had "pre-need" burial plans for their members.

Modern Insurance Still Changing

Insurance as known in the modern world was developed in the 1800s and 1900s and is still in the process of change. In later years it has tended to become a "private tax," a profit to the few rich while being an oppressive burden to many, the entire system being dominated by petty tyrants. Originally it was a way to spread risk among many, thereby making the inevitable losses affordable to all subscribers; now it has become a way to gain excessive premiums from many sources for the enrichment of only a few.

The basis of all insurance is trust and fidelity, as is reflected in the various names the companies have selected for themselves. They are quick to use terms implying freedom from loss, security, trust, solidity, integrity, helpfulness, and the term "insurance" itself, which has a solid sound as it comes off the tongue. And they have been found to be a form of public trust by the courts, which have bound them to deal in "good faith" or be accountable. It is here their strength ... and weakness ... lies, because if they are perceived as untrustworthy, they are of no value.

Another Original Idea

Another of its original ideas was the investment of the premiums for the profit of the subscribers. Since the incoming premium money was making money, this process contributed to the safety of the venture; interest gains, as they were accumulating, were lowering the cost of premiums even more.

The huge investment monies accumulating from premiums provided a source for industrial expansion, purchasing power for the sick and disabled, and (no little thing) a home in widowhood or orphanage. On the whole, it benefitted the individual subscriber and the community at large. Insurance was a service industry. It manufactured nothing, grew nothing, produced nothing. Insurance only served the subscribers as a protection against loss; subscribers have never been allowed to profit from insurance.

Changed to "Profit Centers"

Somewhere along the way, that idea got lost as insurance became a "profit center" for the carriers and their chief executives -- and, sometimes, for stockholders. But rarely now does the subscriber, the one who pays the premium, benefit from the investment income. This is true even of mutual companies where the subscribers, in theory, own the company and it is operated solely from premiums.

There is court testimony where it was described as "against company policy" for a particular mutual insurance company to pay its subscribers anything spendable. This company might upgrade the subscriber benefits in various ways, but never return anything spendable except, as a last resort, to the beneficiary. It was a most amazing and enlightening testimony to say the least. The surplus reserve of the company grew into millions of dollars, much of it categorized as unassigned surplus. The premiums were raised periodically. Why? There was no need to.

Where Does the Money Go?

When investigating "where does the money go?" it comes as a distinct surprise to discover how little goes for taxes (about 10 percent), how beggarly their lower staff is paid, and how few of the profits go to stockholders or mutual fund owners. The great bulk goes to the salaries, bonuses, and perks of the top executives, and to the buildup of the surplus reserve. Indeed, few profits go where they logically belong. Is this the condition in all companies: No, of course not. But it seems to this observer to be a practice of the majority of carriers who find themselves sued for "bad faith claims practices" where their status and policies are exposed to public view.

Purpose of Investment Income

In the life insurance and the health and accident fields, those premiums and their investment income were interrelated and very important items. Insurers knew the young and healthy would cost very little because their losses were comparatively few. But premiums collected were to be invested and, in the subscribers later years (when their expenses were reasonably expected to be higher), the money to cover those losses would be available from combined principal and profits from interest. The premium rates were figured with this fact firmly in mind.

Originally, there was a virtue in a policyholder sticking to the same company, but conversely, as a policyholder aged it became "good business" for carriers to cancel policies and force policyholders to another company who would take them on at much higher rates, because there was no "reserve" built up in the new company. The reserve in the former company then became that carrier's exclusive property.

Keep your eyes on the investment income, because it will soon disappear. The investments and their income are now regarded as "company" money and carriers resent even having to report it as income to the subscribers when there is talk of setting rates.

Justification of Rates

Carriers have arranged in several states to have rates approved after being figured from: premium income; minus administrative costs; minus payouts from claims; and minus dividends paid to stockholders.

Notice that for rate setting purposes there would be no necessary accounting of investments, interest, or rents profits, or of an excessive surplus reserve.

Under these circumstances there is no incentive to reduce rates because an increase can always be arranged to be "justified." Salary and bonuses for executives come under administrative costs and the stockholder's dividends are options within the company's control.

The ownership game, especially with county mutuals, the high risk pool, and entities which are not required to account for profits, enables the carriers to "explain" their "losses" and justify rate increases while reaping huge profits. Obviously, two of the reforms that must be made are in the accounting practices and the carriers' ability to own business entities that escape the reporting requirements. All of their business entities must be accounted for so a true picture of profits and losses can be drawn.

Originally the rates were figured so that everyone could be covered, young and old, sick and well. But it didn't take long to discover that weeding out the higher risks surely did increase profits. Thus the "previous accident or illness" began to play a large role; even more ominous was the rise of the "rider" where a company reduces risks by eliminating a portion of the body from coverage, but rarely lowering the premium. It is very common practice to issue a rider and raise the rates at the same time, an exercise of illogic which only the mercenary can truly grasp.

Some carriers will sometimes force an individual to pay a whole year's premium without being covered, as a condition to being insured at the beginning of the second year, even partially. That is the ultimate, according to many who think it through. It is much more common for a company to collect premiums for a two to three month "trial" period; if illness arises, it is usually presumed to be a pre-existing condition and therefore not covered. But no matter how described, the practice is taking money without assuming risk, which is their promised service. Call it anything you like; it's difficult to refer to it in flattering terms.

It is legal because the wording of the policies are approved by the various state regulatory boards, but despite such approval, it is a practice to be deplored. Summarized: It may be correct, but it ain't right.

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