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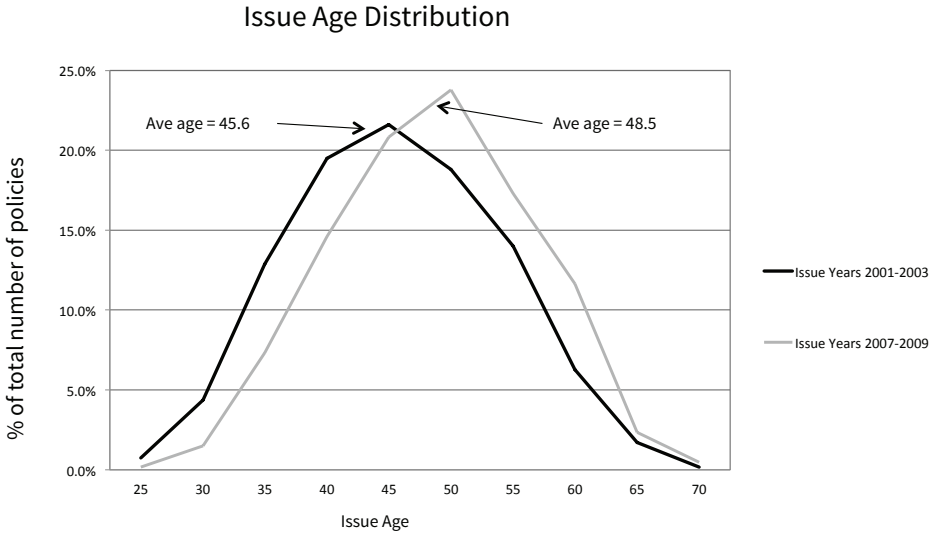
SOA Annual Meeting Session 43 – Current State of the COLI/BOLI Market

By Gregory A. Brandner & David Elias

Session 43 addressed the Current State of the COLI/BOLI Market. Greg Brandner from Munich Re served as moderator, and he along with Julie Decker from RGA and Kelly Rabin from Milliman were the speakers.

Greg opened the session and provided an overview of the COLI/BOLI market as well as remarks about the changing profile of cases and market trends. Highlights of his presentation were:

- The average case size (i.e. number of lives per case) has been decreasing. There are very few new large cases being placed.
- The age profile of new COLI cases is shifting toward older issue ages.
- There is pressure in the marketplace to liberalize guaranteed issue limits. This pressure is being felt from several perspectives:
    - Prior to the early 2000s, the minimum case size for guaranteed issue was 25 lives or higher. Over the past 10-15 years, this minimum case size has been pushed down to 10 lives. Cases are being submitted to carriers today requesting guaranteed issue underwriting on groups as small as 5 lives. Most carriers and reinsurers seem to be holding the line at 10 lives out of concern over the significant anti-selection risk posed by smaller than 10 life groups.
    - Ideally, to minimize the potential for anti-selection, the participation within a group should be 100%. Cases are being submitted to carriers today requesting guaranteed issue underwriting on groups with participation rates as low as 25%. Great care must be taken to avoid anti-selection when considering participation rates below 75%.
    - The definition of "executive" covered by COLI/BOLI plans is being expanded to include employees at lower salary levels. Historically, minimum salary requirements to qualify for these executive benefit plans were typically in the range of $100k-$125k. Today, the minimum salary for inclusion in a COLI/BOLI case can be as low as $50k.
- Executive Owned and worksite programs are becoming more prevalent.
- Technology and third-party data resources are increasingly being considered to assist in the risk assessment process.
- Concentration of risk continues to be a challenge. Both direct writers and reinsurers have limited capacity in some locations, particularly Manhattan.



Greg summarized his view of the current state of the COLI/BOLI market as follows:

- The profile of a typical COLI/BOLI case is shifting, and the trends are not necessarily favourable.
- Historically, mortality experience has been very good (as good as fully underwritten experience).
- Will market pressures lead to a deterioration in experience?
- Can innovation and technology help?

Julie followed with a discussion of a recent market survey, lapse, and mortality experience studies.

A 2011 survey of direct COLI/BOLI writers showed

- Case sizes are shrinking and per life multiples are increasing, with specific insurer concerns about identifying and pricing impaired risks and ensuring the validity of group definitions.
- Marketing pressures are increasing, as attested by smaller case sizes, unique program designs and increases in replacement activity.

CONTINUED ON PAGE 16

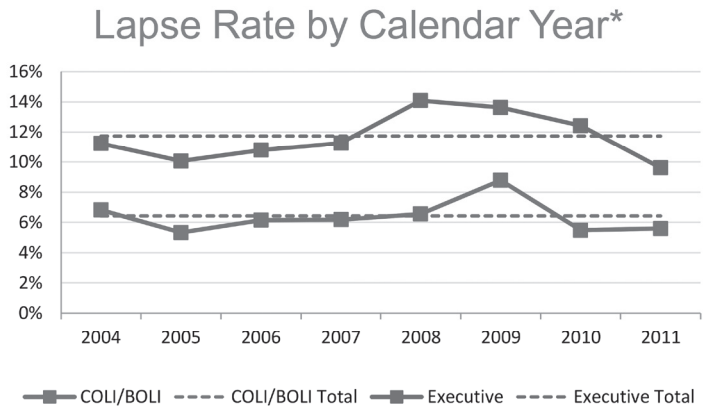
Lapse and mortality experience shows that for RGA's book of COLI/BOLI and EOLI (Executive Owned Life Insurance) business:

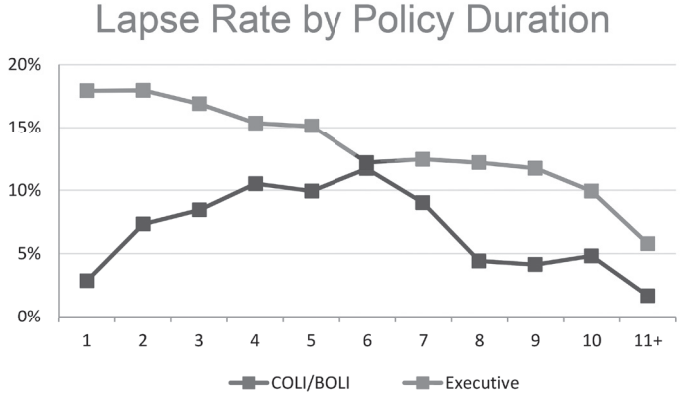
LAPSES – CALENDAR YEAR

- EOLI lapses are higher than COLI/BOLI lapses on a calendar year basis—almost double.
    - o In both markets, lapses spiked during the financial crisis of 2008-2009.

LAPSES – POLICY YEAR

- EOLI lapse patterns by duration are similar to retail individual life lapse rates and generally higher than COLI/BOLI lapses in most durations.
- COLI/BOLI lapses tend to increase by duration until about duration six then start decreasing. For blocks that are predominantly BOLI, lapses tend to be lower and flatter by duration, around 2 to 3 percent per year.





MORTALITY

- COLI/BOLI mortality by count is approx 96 percent of fully underwritten individual life mortality for face amounts $100k+. If substandard risks are excluded, the relative mortality increases to about 102 percent of fully underwritten.
- EOLI mortality is approximately 143 percent of fully underwritten individual life mortality. The increased mortality is primarily due to the impact of individual selection/anti-selection in the EOLI market (availability of voluntary supplemental coverage and/or the option of portability upon termination of employment). There may also be impact from lower socio-economic status, depending on the parameters of the program.
- Both COLI/BOLI and EOLI have higher A/E's for the smaller face amount bands and lower A/E's for the larger face amount bands.
    - o For COLI/BOLI smaller face amounts are generally indicative of smaller case sizes, as face amount limits are generally a multiple applied to the number of lives in the group.
    - o For the EOLI market, where face amounts are usually a multiple of salary, mortality results are interpreted as a reflection of socio-economic factors.
- There has been an increase in early COLI/BOLI claims in recent years. A drill-down into cause of death during the contestable period showed a somewhat disturbing pattern as it relates to deaths due to cancer:
    - o the incidence of cancer deaths by count was almost double compared to fully underwritten individual policies and the general population, and
    - o the incidence of cancer deaths by face amount was almost triple compared to fully underwritten individual policies.

It appears that companies are being selected against, and there may be a need for more robust claims investigations for contestable claims.

Kelly rounded out the session by presenting some innovative ideas that might be helpful in setting COLI/BOLI mortality assumptions. The challenges of pricing COLI/BOLI business include the relatively limited credibility of a carrier's relevant mortality experience and the absence of an industry COLI/BOLI mortality table. She discussed ways to use prescription drug databases as a tool for setting mortality assumptions.

The examples presented utilized Milliman's prescription database tool. This tool captures Rx histories of applicants and runs this data through a predictive model to produce a relative mortality score for the group of lives as a whole. The Rx data is analyzed on a de-identified basis. Because the tool's output applies to the group as a whole, no individual information, rating or score is revealed. This is designed to protect individuals and avoid

confidentiality or other legal ramifications for the insurer. The minimum group size is 25 lives.

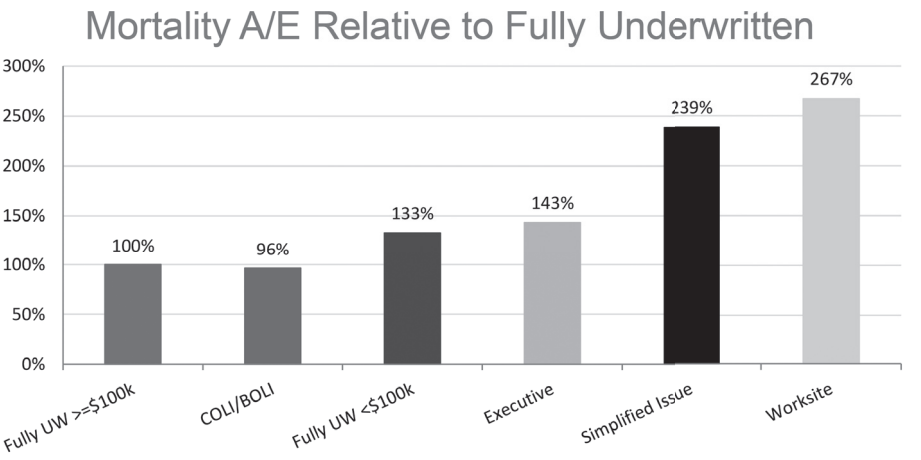
Applications of the tool include

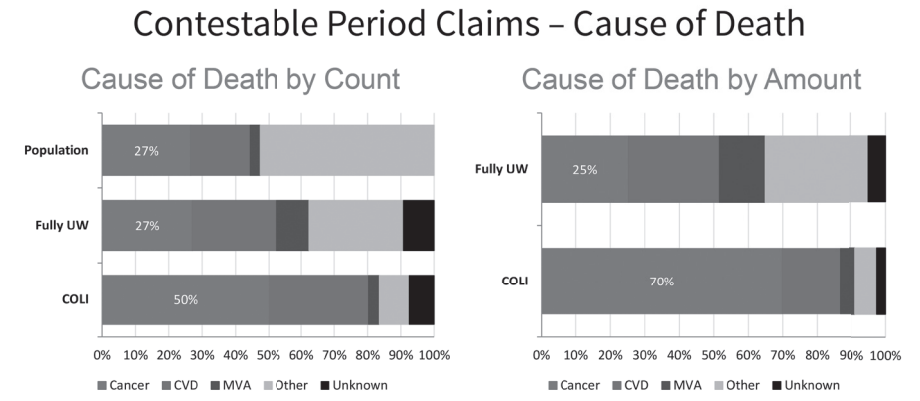
- Rx histories can provide better case-level underwriting information than is available from GI applications and producers, thus enabling the carrier to vary the deal terms by group, whether by price or other criteria (e.g. underwriting multiples.)
- With the database tool, a company can compare in-force blocks of business, for example by distributor.
- Mortality assumptions can be used not just in pricing but also in business planning, DAC unlocking and cash flow testing.

Three topics were raised during the question and answer period.

- To Julie: Q – About how long is the select period based on your recent mortality study? A – Julie: Historically the selection slope has been similar to fully underwritten business, but it remains to be seen if that will hold true for the newer, smaller GI cases.
- To the panel: Q – Regarding concentration of risk, how do you cap face amounts payable in a catastrophe? A – Panel: Generally limitations are determined prior to issue rather than afterwards. Insurers and reinsurers have exposure limits based on their respective risk tolerance levels and financial resources. Manhattan capacity is a concern across the industry, and exposure limits such as $100M of net amount at risk per location are common as a concentration of risk management tool.
- To the panel: Q – To what extent do BOLI and COLI mortality experience differ if any? A – Greg: One direct writer's mortality study with more than 1,200 claims identified BOLI vs COLI data. In that study BOLI experience was approximately 10 percent higher than COLI. This is possibly attributable to smaller BOLI case sizes and/or lower face amounts. Kelly: BOLI cases written in the 1990s tended to be larger in size and their mortality tracked relatively closely to COLI mortality.

Copies of all three presentations and an audio recording of the session are available on the SOA website. ■





Population data based on 2011 data for ages 25-64 from CDC, National Vital Statistics Reports, Vol. 61, No. 6, Oct. 10, 2012 (over 663,000 deaths)
Fully UW data based on RGA claims with dates of death 2009-2013, face amount $100k+, issue ages 20-69, full underwriting, durations 1-2 (over 3300 claims)
COLI data based on RGA COLI/BOLI claims with dates of death 2009-20142Q, durations 1-2 (213 claims)

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