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UNIVERSAL LIFE ENHANCEMENTS

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- Non-guaranteed elements: design, pricing, filing issues
- What problems has TAMRA 88 imposed on universal life product designs?
- Actuarial concerns of Living Benefit Riders, guaranteed features in today's design, joint life products

MR. ALLAN HALE JOHNSON: My part of the program deals with the design, pricing, and filing issues relating to the non-guaranteed provisions of universal life products. This is not going to be a step-by-step teaching session but rather I am going to try to give you some insights into the perspectives that you should have in managing your universal life business through the way you manage your non-guaranteed elements. I'll do this by giving a little history as to how non-guaranteed elements in universal life emerged together and then I'll talk about the way we've been managing these elements over the past few years. Finally, I'll talk about the ways you may want to manage these elements in the future.

First let me talk about what I view as the scope. That is which elements are we talking about when we talk about non-guaranteed elements. The most obvious elements that come to mind are the credited interest rates and the mortality deductions assessed in the buildup of account values and cash values. I will talk about those elements, but I would like you to think a little more broadly about all of the elements of universal life products. For example, you want to consider the premium flexibility or face amount flexibility provisions that are contained in these contracts.

Have you guaranteed this flexibility 100%, or are these provisions also non-guaranteed elements to some extent? I think sometimes we focus too narrowly on the obvious pricing elements of the universal life design, namely the interest credited and mortality deductions, and we overlook the other elements of the product which are also capable of being guaranteed or non-guaranteed.

Another element of scope relates to where do we draw the line between a guaranteed element versus a non-guaranteed element. Does the provision have to be contractual before we consider it a guarantee? What about the implied promises that you might be making in your marketing material or statutory disclosures? Are those promises guarantees or not? Frankly, I believe that we can get into a lot of trouble over the non-contractual promises we make because sometimes we don't consider them as closely as we consider the contractual guarantees. In any event, my point is that I don't believe that every element is black or white with respect to whether it falls into the guaranteed category or the non-guaranteed category. One of the issues that I will cover is the fact that if non-guaranteed elements aren't managed properly they can become guarantees from a risk exposure perspective.

So let's go into how non-guaranteed elements came about. Many companies had introduced the concept of indeterminate elements or non-guaranteed elements prior to universal life. For example, in the 1960s, Occidental Life had a permanent non-participating whole life contract which had a provision permitting us to change the premium rates prospectively. In addition, many companies used non-guaranteed elements as a means to minimize non-tax-deductible premium deficiency reserves.

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However, indeterminate or non-guaranteed elements really took off with universal life for many reasons, relating both to the product and to the environment in which the product came out. Specifically, we had uncertainty caused by inflation, high interest rates, and competition from money market funds for the savings dollar. These circumstances helped fuel both universal life and non-guaranteed elements, but universal life's design itself also spurred the development of non-guaranteed elements. I am going to take you through one environmental issue, namely the situation of high interest rates, to demonstrate my point.

The double digit interest rate environment in the late 1970s and early 1980s led to the use of high interest rates in the pricing of both universal life and traditional whole life products. The uncertainty over these high interest rates, combined with valuation concerns, led to their use on a non-guaranteed basis in both universal life and indeterminate premium forms of traditional whole life. However, in addition to its direct impact on the greater use of non-guaranteed interest rate provisions, there was also an indirect impact because of the effect high interest rates had on the popularity of universal life. In the design of traditional products, even those of the participating or indeterminate premium design, the pricing interest rate is not always visible to the customer. The only rate that the customer might see is the non-forfeiture interest rate which was typically 4-5.5% in the early 1980s. This led many customers and even some field people to draw a conclusion that this was the interest rate that the customer was earning under these contracts. On the other hand, with the universal life design, the interest rate is visibly displayed for the customer in the buildup of account values and cash values. Therefore, although these high interest rates led to a pricing response on both universal life and traditional whole life, it was a more visible response on universal life. This, in turn, gave the impression that universal life was by definition somehow more competitive than traditional forms, even those offered by the same company.

So, basically the non-guaranteed interest element came about both from uncertainty about the future course of interest rates and the universal life product itself, which was also fueled by this interest rate uncertainty. While I won't elaborate on it, the same dual drive led to the development of non-guaranteed mortality charges and expense charges.

However, simultaneously with companies removing some of the risk with respect to these elements, they added to their risk in new areas. The primary new risk added was associated with the flexibility allowed with respect to premiums, both how much we would accept and when we would accept them. Premium flexibility, which had previously been either actually non-existent or had been non-existent by company practice, was now a guaranteed element. We viewed these products as being truly universal -- that is, able to meet every need of every customer and to serve the customer throughout his or her lifetime. We believed this flexibility had to be a guaranteed element rather than a non-guaranteed element.

Both universal life and non-guaranteed pricing elements led to some new problems which needed to be managed. The advantage that universal life had of explicitly showing each pricing element became a disadvantage in some respects.

Under traditional products, all of the pricing elements are combined in deriving premium rates, cash values, and dividend scales. A gain from one source, for example mortality, versus what was in the pricing assumptions, can be used to offset a loss from another source -- for example, deficient interest rate spreads. However, since the major pricing elements of mortality, interest and expense are explicitly shown under universal life, it became important in the minds of some to be competitive with respect to each element of the pricing process, both at the time of the original pricing and at future re-evaluations of non-guaranteed elements. Not only was it apparently important to be competitive with respect to each element, but some companies went further and made non-contractual promises that they would remain competitive with respect to each element. For example, direct (or more usually indirect) promises were made to agents and consumers that companies would maintain their interest rate spread in all environments. These promises were often not appropriately qualified to say, for example, that interest rate spreads would be maintained as long as the lapse rates, mortality rates, etc. met the pricing assumptions. Thus, the total risk increased to the extent that we looked at these risks independently rather than collectively.

Another new problem which needed to be managed resulted from the illustration tool used for universal life. Originally, illustrations of projected universal life product values were used to

explain the product. We used them to show how account values and cash values would grow as interest is credited and as charges for mortality costs and expenses were deducted. However, over time these sales illustrations seemed to become the product rather than a tool to explain the product. In evaluating the products of two companies, the one with the higher set of projected values was sometimes viewed as being better. This led to marketing pressure to make unrealistic illustrations. For example, the double digit interest rates of the early 1980s were projected to last for the 30 year illustration. Other companies projected that mortality improvements would be passed on to customers through the use of reduced mortality deductions in the future. As an industry, we sometimes lost our focus on selling life insurance to meet a customer's need and instead developed a focus on beating some other company's illustration.

A third problem which emerged from the use of non-guaranteed pricing elements in universal life was the lack of focus on the guarantees being made. Often they were viewed as being some sort of theoretical item which would never be applied, so they were designed merely to satisfy regulatory requirements relating to reserves, securities laws, or non-forfeiture values. For example, some states require that interest rate and mortality charge guarantees be equal to the non-forfeiture rates. Since companies were not focusing on these guarantees, they often caved in too easily to these demands. We saw some companies that occasionally would be offering 5.5% interest rate guarantees over the life of the contract in order to get policy forms approved. These interest guarantees, combined with premium flexibility guarantees, may have exposed some companies to an excessive interest rate risk which has not been adequately examined.

Finally, the premium flexibility provisions became a problem for many companies. In order to market these products companies had to pay the same sort of front-ended traditional whole life type of commissions. Yet the premium flexibility provisions often meant that in renewal years, the policyholder could keep the policy in force without paying premiums for a few years. Traditional whole life products would have lapsed, and the company would have received some offset to its up-front commission costs by the release of the difference between the reserve and the cash value. However, flexible premium universal life products didn't lapse. They remained in force until the mortality deductions assessed to the account values caused these account values to fall to zero. In essence, the customer got an extended term coverage based on the account value, and not the cash value net of surrender charges. To make matters worse, the implicit cost for this extended term coverage was the aggressive current non-guaranteed interest rates and mortality charges rather than the traditional cost, which would have been at a more conservative non-forfeiture interest rate and the Commissioners Extended Term mortality rates. So premium dormancy risk, rather than lapse risk, became the primary risk with respect to rear end-load universal life products. This risk arose from the premium flexibility provisions that were guaranteed in universal life contracts rather than non-guaranteed, as they had been in traditional products. The cost of this dormancy is difficult to recover on this business for the reasons I previously explained, namely that each of the pricing elements was explicitly shown and often promised to be priced independently. Thus, for example, we couldn't easily increase our interest rate spreads to pay for unexpected premium dormancy costs, both because of competitive pressures and non-contractual promises which had often been made or implied.

I'll now cover how the industry has been responding to some of these problems which have emerged. First of all, to manage the premium dormancy risk, required annual premium provisions have been devised. There have been different forms of these provisions. One form calls for charging higher mortality deductions, such as the guaranteed scale, if the premium received isn't above a certain level. Another form calls for a lapsation of the policy if the premium received each year isn't above a certain minimal level, such as $25, and if the cash value (as opposed to the account value) falls to zero. A third form measures the cumulative premium paid per $1,000 against a cumulative annual minimum for a certain period of time, such as five policy years. Required minimum premium isn't paid, the policy lapses for its cash value, rather than continuing in force as a form of extended term insurance, calculated off of the higher account value.

Required annual premium provisions are sort of the stick approach to managing for higher renewal premiums. In addition, there is a carrot approach -- namely the use of persistency bonuses. These persistency bonuses tend to take the form of higher current credited interest rates or lower current mortality deductions after a certain duration if cumulative premiums are paid above a given level. These persistency bonuses themselves can either be guaranteed or non-guaranteed provisions. If they are non-guaranteed, they can be managed analogously to the way

non-guaranteed interest crediting or mortality charges are managed. However, there is one additional question to consider in pricing, managing and regulating these persistency bonuses. Are these bonuses too good to be true? Another way of asking this is, are they lapse supported, priced under the hope that very few policyholders are going to be around to collect on them? If a persistency bonus is guaranteed or if it isn't guaranteed but also isn't lapse supported, then these design features can be a positive thing for the industry if it works as a means of encouraging persistency and renewal premium.

Thirdly, there have been responses in the area of controlling unrealistic sales illustrations. In response to the problems caused by using aggressive assumptions in our illustrations, several disclosure requirements have been developed. First of all, there is a new schedule of interrogatories regarding non-guaranteed elements in the NAIC blank along with the related actuarial opinion. Secondly, there are guidelines and recommendations of the AAA relating to non-guaranteed elements. Thirdly, we have advertising and cost disclosure regulations. Finally, there are disclosures regarding repricing intentions that are made at the time of product filing in some states. You need to think through the consequences of your company's responses to these disclosures because they may create non-contractual guarantees which could block your company's strategic response to the future. I'd advise that the development of your response not be 100% delegated to a lower level of the organization without a review at very senior levels of the company.

Finally, companies are responding to competitive pressure on non-guaranteed elements by trying to take advantage of the renewed interest in the marketplace in the guaranteed elements provided. This change has been fueled by the stock market crash and the lower interest rates which we've seen since the early 1980s. What's gone down can go down again.

Now I'd like to move from where we've been in our management of non-guaranteed elements on to where we need to go. There is an underlying premise behind my recommendations which is a personal firm belief that competitive pressure will come more and more from outside our industry, either from other financial institutions or foreign insurance companies. However, I don't believe that as an industry we really respond as if we believed that this is from where our competition will come. If we did, we'd be looking more closely at what these companies are doing in all areas of their business. For example, what are they doing with customer accounting statements? How do they handle product development and product implementation? What asset liability management techniques do they use to manage their spread in the sources and uses of funds analysis that they are doing? Are you even looking at what these other institutions are doing, or are you only concerning yourself with what other domestic life insurance companies are doing? In like manner, in looking at how we should manage non-guaranteed elements and guaranteed elements, we do need to look at what these other institutions are doing in this area.

The first and foremost area to deal with in managing non-guaranteed elements is the issue of integrity. I believe there needs to be an increased examination at the most senior levels of all companies about integrity and how integrity interplays with our concepts of equity and with our setting and resetting of non-guaranteed elements. Disclosures such as those required for the NAIC blank are attacks on the symptoms, not the disease. The disease is a lack of integrity, or more likely, inconsistencies over what we mean by integrity, combined with the notion that the product is the illustration, so if we just stretch our integrity, we can have a better product.

Here are some specific issues which demonstrate questions of integrity which I would like you to examine as you decide upon the way you should manage non-guaranteed elements.

First, we need to rethink which definitions of equity are in the best interest of our customers and which aren't. I'm going to consider the following hypothetical companies with respect to their interest performance over a five-year period. These companies market identical universal life products.

Underpriced Life misassesed the pricing of its universal life product. It believed that a 1% interest rate spread was sufficient, but as it went along it finally realized that 1% was inadequate for the company. It kept its marketing promise to maintain spreads, and so it went bankrupt.

Insolvent Life priced with an adequate spread, and it earned that spread -- but due to other causes, such as poor performance in other lines of business, it also went bankrupt, and like Underpriced Life it subjected its policyholders to its state's guarantee fund.

Poor Investors Life priced adequately and didn't have any problems in other lines of business, but it had a very poor investment department. The company faithfully maintained its promised interest rate spread to the joy of its customers who were very pleased that they were treated equitably.

Dynamic Life, on the other hand, had a very successful investment department and was able to improve the yield on their portfolio without resorting to the use of low-grade bonds.

Dynamic Life was the only one that increased its spread. Which one would you rather do business with as a customer? However, Dynamic Life's approach violates many people's perception of equity, whereas Poor Investors' approach is perceived to be equitable. By establishing standards or promises that insurer's profits can't increase beyond that established at issue, aren't we demotivating companies from pursuing the efficiency improvements and excellence in performance that are needed to keep companies in our industry healthy? Isn't that contrary to the policyholder's interest? The point is we need to go beyond thinking about integrity only in terms of customers getting an equitable share of our performance. Rather, we need to consider good performance itself as part of our promise to our customers.

A second point under the subject of integrity is don't make illegitimate promises to either customers or regulators. Here are just two examples of promises which in my mind are illegitimate and hence not demonstrating true integrity.

First, some companies have an indeterminate element policy which calls for adjusting for favorable experience but not unfavorable experience. Since the managers of the company represent both the stockholders and the customers, is that treating the stockholders with equity? Is it legitimate to make a long-term promise which could threaten solvency? Does that show integrity to shareholders or customers? Another form of illegitimate promise occurs when we promise to employ a repricing strategy for which we don't have the necessary accounting information or statistical information, and which we couldn't get without a prohibitive cost. For example, some of the philosophies which call for maintaining interest rate spreads at each interest rate cell level would require asset segmentation down to that same cell level. For companies with multiple products and new money interest rate methods, that would be prohibitively expensive, both from an accounting perspective and from investment management perspective. Before you make such a promise, you will want to consider what sort of tracking and implementation is doable at a reasonable cost.

The second area of change which may come about will result from changes we make in our pricing and product design techniques. It is likely that pricing and product design methods will trend toward the techniques used by other financial institutions. This may happen as the result of competition from these institutions, or it also could be the result of an acquisition of a universal life company by other financial institutions. An example of a change which could occur from this force is that we might reprice more frequently. I realize there are currently SEC considerations, but over the long haul can we really afford to restrict ourselves to annual changes in credited rates if Joe's Bank changes its credited rate monthly or daily?

Thirdly, we need to stop making promises, guaranteed or non-guaranteed, that aren't marketable or don't meet a customer need. Does your bank provide you a 30-year illustration? Does it promise to maintain profit levels when it issues a checking account? If not, why are you buying from that bank? Does the customer want a promise that we won't have a greater profit on his business than we projected at issue? Or rather does he have a long-term need for permanent insurance which he wants us to meet in a cost competitive manner?

Finally, there is the issue of managing the in-force business. Often when we talk to actuaries about their indeterminate element repricing philosophies, it almost sounds like they believe that repricing is sort of what falls out or happens to us. I don't get the sense that they focus on the opportunities for managing the in-force business toward profitability, with non-guaranteed elements being both a tool and a beneficiary of such management. In the past, most of the action in an insurance company was in the product design, product pricing, and sales process -- that is,

all the up-front stuff. After a policy was sold, we measured the profit results, but we didn't manage them. The profitability of universal life and our ability to maintain attractive credited interest rates and mortality charges, however, are going to be highly dependent upon managing the business after the initial sale.

Some specific ideas follow. The first four ideas are additional thoughts on how you can manage for improved renewal premium beyond the product design suggestions for persistency bonuses and required annual premiums that I discussed before.

First, consider your statements of account as marketing material to get more premium and better persistency. For example, make the customer comfortable by making these statements user friendly (that is, readable). Provide information on how a customer can make an additional deposit or add some riders. You might want to include an envelope and payment stub for remitting an unplanned premium or applying for additional coverages.

Second, you might want to use premium reminder notices under flexible premium products. At Transamerica, under our flexible premium universal life products, if a billed premium isn't paid, we send out a reminder notice. Our observed responses to these reminder notices in 1988 was 12% of the reminders. That amounted to 4% of all of our renewal premium.

Third, pay the field for renewal premium. You could consider paying either higher renewal commissions or a percentage of asset-type compensation, regardless of what you might have contemplated when you developed the product, if by doing so you can increase your renewal premium and profitability. We need to pay at least at a level sufficient for them to cover their servicing costs. If not, the servicing will deteriorate which will increase your susceptibility to raids on your business, even if the current agent doesn't replace it himself.

A fourth way to manage for renewal premium could be to expand the use of higher current mortality charges for dormant policies versus those which are premium paying. In addition to contractual provisions which call for this on a guaranteed basis, you might want to consider managing your non-guaranteed elements, recognizing that the mortality experience under a dormant policy could be more like extended term mortality. Obviously, there might be a restraint on any company which has promised away its right to use premium dormancy as a factor in setting current cost of insurance charges. Another restraint would be to consider the way you market business with vanishing premium. Your definition of dormancy would need to be designed carefully to not inadvertently sweep some of that in.

Finally, more attention needs to be paid to managing the spread for the book of business on both the asset and liability sides. Some universal life product managers focus only on the liability side, that is, the interest credited side. Sometimes they delegate away to the investment department the management of the asset side. They might pay attention to it for purposes of asset and liability risk analysis, but they don't think of it from the perspective of spread management analysis.

I'd like to summarize my suggestions by saying that in the past, we've managed non-guaranteed elements in a traditional life insurance company fashion. Namely, we managed them through product design features, regulatory and customer disclosures, conceptions of equity based on the model of participating life insurance, and a black and white attitude toward what is a guarantee and what isn't. To further expand upon the last point, we had an "entire contract" mentality toward guarantees; if it wasn't stated in the contract, it wasn't guaranteed.

In the future, we'll need to pay more attention to the basics of managing any business, because our competitors will be playing this way.

Specifically, we are going to have to know who our competition is. We are going to have to better define and understand the concept of equity and operate with integrity. We are going to need to understand our customer's needs better, and we must manage our existing business, not just new business.

Some of my suggestions are controversial because they come from a focus on what our non-traditional competition is doing rather than traditional life insurance analogies, such as participating insurance. In addition, some of my suggestions are contrary to regulatory requirements in some states. Obviously, if you choose to do universal life business with non-guaranteed

elements in those states, you need to follow the requirements in those states where they conflict with these suggestions. But, you should seriously consider the consequences before you make any promises which you might come to regret later.

MR. JOHN T. ADNEY: I am going to be talking about the effect of the 1988 law on universal life products. We have not yet received word on whether there is going to be a 1989 law; but just in the event there is, there are meetings in progress on Capitol Hill with the professional Tax-Writing Committee staff to go over technical corrections to the 1988 Act on behalf of interested parties within the industry. If that happens, then the technical corrections, or whatever comes out of those discussions, will become a title in whatever the next tax bill is, which will itself need technical correction later.

The 1988 Act, in some respects, dealt lightly with life insurance, but in a variety of other respects, did not deal so nicely with life insurance contracts. The 1988 Act, of course, did not change a couple of key elements in any life insurance contract sale, and it's good to keep those in mind. The death benefit of life insurance is still tax free, despite some of the best efforts of both some staff members on Capitol Hill, and people within the industry, to undermine favorable tax treatment. In addition, while the tax-free nature of the death benefit may not be too controversial, the tax deferral on inside buildup, turning into exemption upon death, is controversial. It carries a large price tag in tax revenue terms, and that is known to the congressional staff and the Treasury staff. Some of them would like to do away with the tax-deferred inside buildup. That has not been done per se, but what we see is a sort of continual gnawing against the inside buildup deferral. That to me is what the story of the 1988 laws is about, as well as the 1986 law, the 1984 law, the 1982 law, and whatever the next law is. I have put together a statement to that effect in an article that is in the process of being published in the *Journal of the American Society of CLU and ChFC*. Part I has been published in the May 1989 issue, and that sets forth the history. Parts II and III will be in the July and September 1989 issues, and they will give you much of what I am trying to say, although what I am going to say is focused on universal life, and the article sweeps a little more broadly than that.

The 1988 Act did change the treatment of certain distributions from certain life insurance contracts, and that is where the trouble starts. The treatment changed if the distribution, including a policy loan, comes from what we call a modified endowment contract (MEC). Now you need not go out and search your literature to find out what a MEC is, because it only exists in the Internal Revenue Code. It has a Code section, Section 7702A, which defines it, and that is solely for purposes of a couple of paragraphs of Section 72(e) of the Code and Section 72(v), which now imposes a penalty tax on distributions from MECs. The whole purpose of the exercise is to say how life insurance contracts' distributions would be treated as if they were coming out of annuity contracts. As you know, partial withdrawals and loans from annuities are taxed on a "gain out first" or "last in, first out" (LIFO) basis, and they attract a 10% penalty tax, unless an exception applies. Unfortunately, the 1988 Act also dragged along with it some changes to Section 7702 itself, and that is perhaps even more troublesome. Let's talk about modified endowments first, and then get into Section 7702.

As you know, we have a LIFO rule for distributions from MECs -- for partial withdrawals and loans, and for assignments of contracts. One may ask what happens if one collaterally assigns a contract in connection with a split dollar arrangement -- is that caught up in this? I can't tell you it's not caught up. It may very well be. If there is a gain in the contract or a gain emerges as the assignment is outstanding, and the contract is a MEC, you may very well have tax in that situation. That doesn't make a lot of sense in the split dollar area, because we already have rules for taxing employees on the value of the economic accruals, but the potential is there.

The way the LIFO rule works is not difficult. If you have a policy that is a MEC with a $10,000 cash value for which you have an $8,000 investment in the contract (basically the premium paid), and you reached in and took out the difference ($2,000), that would be treated as income. It used to be that it would be a non-taxable recovery of the investment in the contract.

Well, that's fine, but what if we have a back-end loaded contract? In the back-end loaded contract we're going to have a surrender charge coming out against that partial withdrawal, so do we give the taxpayer credit for it? No, we don't. The rules in the 1982 (TEFRA) law, in the General Explanation or Blue Book published by the Joint Committee on Taxation at the end of 1982, specifically went through an example on that and showed that the policyholder does not get

credit for that surrender charge until the contract is fully surrendered out. So, the policyholder may very well end up paying tax on the full amount of the gain. In my example of $10,000 cash value, $8,000 investment, and $2,000 withdrawal, and even though there would be an additional charge for the partial surrender, you still have $2,000 of taxable income. Well, suppose that after a partial withdrawal, draining all the gain out of the contract, the policyholder surrenders the contract. Surely at that point, he gets a loss deduction, right? No, not necessarily. There were cases in the 1930s and 1940s which dealt with the availability of loss deductions from life insurance contracts, and in those cases it was decided that loss deductions would probably be unavailable in the case of life insurance contracts, barring some exceptional facts.

So the treatment of the back-end loaded contract is not very kind. That does not mean that you shouldn't do it, of course. If you have a back-end MEC, the economics may still justify having it, even if it's taxed this way; once the surrender charge wears off, who cares anyway?

There has previously been a form of LIFO rule existing on life insurance contracts. The 1986 Act elaborated on that and expanded it, and created it as Section 7702(f)(7)(B) through (E). This rule, which deals solely with partial withdrawals in cash, is a form of a LIFO rule. It was designed so as to collect as little tax as possible from most sorts of partial withdrawals. But it does effectively impose a LIFO type treatment on withdrawals from fully paid-up contracts, particularly in their first five years, so it would have a very definite effect if you had a partial withdrawal from a single premium policy. Well, if you had a partial withdrawal today from a newly issued single premium policy, you would have LIFO taxation anyway. And if you went out of your way to avoid modified endowment status by complying with the new Section 7702A seven-pay test, you are very unlikely to run into the clutches of Section 7702(f)(7)(B) through (E). The provision may be deadwood, but we need a comprehensive study on it to prove to Congress that it is deadwood. As to newly issued contracts, my only point here is that the existing LIFO rule never did have that much impact, except on older contracts to which Section 7702A does not apply. Still, you'll need to keep on testing for "(f)(7)(B)" problems.

If you wind up with an MEC after it was issued -- sometime during its first seven years, the seven-pay limit is crossed -- the law instructs you to go back retroactively and treat loans and other distributions within the prior two years as being distributions from an MEC. In case you are wondering how that is going to be administered, I don't think anybody knows. The IRS certainly doesn't know. We've talked to the people there. We've received all sorts of advice, none of which seems to produce an answer, because the IRS has nothing to work with on the subject. I think this basically becomes a tax return amendment problem for the policyholder. It is very unclear to me that companies even so much as have a reporting obligation on prior taxable years' distributions from contracts that have just now become MECs. To cover yourselves, you could do what you do with any new distribution from an existing MEC, and that is report on it and offer to withhold on it, but it is very unclear what your obligation is.

There are two other rules you need to watch out for with respect to distributions. One is the penalty tax, and the other is a brand new rule we call an aggregation rule. The penalty tax is very much like the annuity penalty tax of 10%, and the penalty goes off once the taxpayer reaches age 59 1/2, becomes disabled, or annuitizes the contract for life. The age 59 1/2 relief from the penalty tax refers to the taxpayer, not the insured; so forget how old your insured is, focus on the taxpayer (typically the owner of the contract). Also, it is important to keep in mind that certain taxpayers don't age; corporations, for example, will not age or become disabled in these terms. If a corporation owns an MEC, it is very unclear how that corporation could get rid of the contract, short of the death of the insured, without incurring the penalty tax.

The other rule is the aggregation rule of new Section 72(e)(11), the rule that was put in as an anti-abuse measure in the law, in the "eleventh hour" of the conference on the 1988 law. It is being worked on in a notice that the IRS hopes to issue. The IRS had hoped to issue it in January, but it has gotten hung up in the course of discussions with the industry and transitions to the new administration. There should be a notice out soon telling us how we aggregate modified endowments and annuity contracts. This is solely for the purpose of measuring gain on distributions under the LIFO rule with respect to these contracts. The rule simply says that if you have more than one MEC (or annuity) issued to the same policyholder within the same 12-month period by the same insurer (or its affiliates), you will aggregate those MECs (or annuities) issued after June 20, 1988 (after October 20, in the case of annuities) for the purpose of determining the amount of gain in the contract.

It's going to be very messy to administer these rules, but before you could administer them you have to find out what they mean. The IRS is still trying to figure that out. It is not sure whether the 12-month period is really a 24-month period. It is not sure who the same policyholder is, and it's not sure who the same insurer is, but it is going to tell you soon. Hopefully, within the next couple of months, we will see a notice of proposed regulations on that subject, which will have the force and effect of law. It may not make a lot of people happy, particularly since the focus of the notice will be on the split annuity contract. I think some levels of the Treasury (and the IRS), are prepared to come down saying that the immediate and deferred pieces of the split annuity must be aggregated for this purpose, and that the immediate annuity will not receive the exclusion ratio but will simply be treated as a series of partial withdrawals.

Now moving from that cheery subject on to the definition of an MEC, I think you all know that there is a seven-pay test, but what you've learned in the course of dealing with it, as we all have, is that none of us really is terribly sure how to apply that seven-pay test. An MEC is a contract entered into on or after June 21, 1988, that fails a seven-pay test, or that is received in exchange for another MEC. If you are dealing with Section 1035 exchanges of contracts, you need to watch the possibility that the contract you are taking in to replace in the exchange is itself an MEC. If it is, that taint will carry over to the new contract. That is an important piece of testing to be done, and today a lot rides on the grandfather rules in Section 7702A to determine whether that old contract is a modified endowment. Over time, the old contract could very well be subject to the Section 7702A seven-pay test from the date of issue in its own right, and then you'll need to examine it from that perspective. I'm not really sure how you'll make that determination ultimately, nor how much the IRS will expect of you, but at this moment, at least a good faith effort is going to have to be made to determine whether the old contract received in exchange is an MEC.

There is another requirement for contracts to be considered MECs. According to the way the statute is written, it must be a life insurance contract under Section 7702. Now you may consider that to be redundant or just purely a minor definitional matter, but it raises a big question as to contracts that are life insurance for tax purposes that don't have to meet the requirements of Section 7702, such as contracts generally issued before January 1, 1985 (including Section 101(f) universal life contracts). Can these ever become modified endowment contracts by mutation of their benefits under the material change rules of the effective date of Section 7702? Well, the way the law is written, the answer is no, they cannot become modified endowments, which means you'll want to hang on to them (or at least the policyholder will). However, to clarify whether this is a correct reading of the law, this and other questions are being asked of the Joint Committee on Taxation in the meetings that are occurring on Capitol Hill.

Obviously, if non-modified endowment contract treatment is important in many sales, procedures and systems must be put in place to police compliance with the seven-pay test, including the material change rule and the benefit reduction rule under the seven-pay test.

For universal life contracts that are operating under the guideline premium test of Section 7702, the interplay between the guideline premium test and the seven-pay test must be watched. That is a fascinating interplay. I am going to throw out some numbers here and hope you'll forgive these (these are lawyer's numbers, not actuarial numbers), but generally speaking, I supposed there would be some age for which these numbers would be true. A guideline single premium for a $100,000 contract (assuming an issue age of 35) might be in the neighborhood of $16,000. Let's assume the seven-pay premiums are $4,000 annually, using 4% interest (the minimum permitted by the statute), and no expenses (as the seven-pay rule requires). What that means is, if you pay more than four of the $4,000 premiums, you go over the $16,000 guideline single premium limit, which you should not be doing in a guideline premium contract (at least until around the 10th, 11th or 12th year), and therefore you won't have a life insurance contract anymore. So to comply with the seven-pay test, and Section 7702, you wind up with a four-pay test, but a special version of the four-pay test. Now you also note the contract won't be paid up on its guarantees. Well, suppose you had a 6% contract to make sure that the $16,000 would pay it up on the guarantee. It still won't be paid up on the guarantees, if you are trying to avoid modified endowment status, because you can only pay in $4,000 a year. That's too slow of a payment pattern over four years, even at the 6%, to pay the contract up on the guarantees. I've just told you all I know about actuarial science, but I think that is generally true. Now someone may be able to dispute that, but I think that is the sort of interplay between these provisions with which everyone is struggling. You don't have that struggle under cash value accumulation test contracts. You can pay the full amount of

the seven-pay premiums, I think, under those contracts. You may have to pay them over more than seven years, depending on loads, substandard charges, and the like, but you can pay them. Will Congress grant a guideline seven-pay premium for a universal life type policy in order for it to be able to compete with us? Well, I don't know, but I doubt it.

To apply the seven-pay test, you need to know several rules, such as what the "amount paid" for the contract is, and how riders are treated.

As far as the "amount paid" is concerned, you're testing an accumulative amount paid against an accumulative seven-pay premium limit. That is how the seven-pay test works, very much like the guideline premium test, although the limit has no expenses factored into it. The amount paid in reality includes the total amount paid in for the whole contract. Some people have raised the question, "Can I exclude some of the amounts?" I think you are walking on thin ice if you try to exclude some of the amounts. There may be a way to exclude amounts for non-qualified additional benefits, as that term is used in 7702(f)(5). If the premium is separately stated for those non-qualified additional benefits, and there is no pre-funding (there is no opportunity to use the cash value of the contract to pay for the non-qualified additional benefits), you may be able to exclude that premium, but even that is not clear. Beyond that, I don't know that you have the right to exclude any part of the premium, no matter what it is being paid for, if it's collected on the basis of the specification page of the contract.

What about paid-up addition riders? The premium for the paid-up addition rider must be counted in the amount paid under the seven-pay test. Now the good news is that you may also increase the seven-pay limit by factoring in a seven-pay premium for the initial benefit of the paid-up addition rider. As far as qualified additional benefits (QABs), you can raise the limit by the amount of the present value of the charges for the QABs (not the benefits themselves). If you go beyond the QABs, and beyond the paid-up addition riders, you are on your own. We don't know whether you can take any other benefits into account, but then again we've never been able to really determine where, under 7702 itself, the contract stops and something else starts. So you are off in fuzzy areas if you are trying to deal with that.

You can reduce the amount paid under the contract under a 60-day return rule, similar to the rule under Section 7702, if you return premiums, with interest, within 60 days of the close of the contract year (as defined in 7702A). You can then reduce the amount paid in the contract for purposes of the testing during that contract year under the seven-pay test, but you must provide an interest payment with that. We don't know the exact amount of that interest payment at the moment.

Other rules you need to cope with under Section 7702A:

1. People have asked whether Option 2 or Option B death benefit increases may be taken into account in computing the seven-pay limit. My answer is that you run a great risk if you do it. Congress is being asked to clarify that. The statute is worded in a very ambiguous and misleading fashion right now, but I think we'll get a clarification from Capitol Hill saying you may not reflect Option 2 or B increases in the seven-pay premiums. It is a different story when we get down to material changes and talk about the necessary premiums, where you can include the Option 2 or B benefit.

2. Benefit reductions within the first seven years require a contract to be retested under the seven-pay rule, retroactively, with the seven-pay premiums being calculated as if the reduced benefit level had been in place at the beginning of the seven-pay period. Material changes, which we will discuss shortly, presumably restart the seven-pay period for this purpose. Because the actual "amount paid" at any time prior to the reduction will be measured against the seven-pay premiums computed at the reduced benefit level, the contract may well fail the seven-pay test when the reduction occurs. This treatment is required under the statute in order to prevent abuse, by turning contracts complying with the seven-pay test into single premium contracts before the seven-pay period is over. In view of this, the rule will probably be applied broadly by the IRS. So, the best course of action to take with regard to benefit reductions during the first seven years of a contract, or the seven years following a material change, is to avoid them.

3. Material changes, as you know, require reapplication of the seven-pay test to a contract, although not retroactively. What is a material change has been the subject of much discussion in the statute, the legislative history, and the industry, for it is a complicated, even tricky, subject. In general, a change in a contract's benefits or other terms, which represents a difference from the contractual structure upon which the seven-pay premiums were determined, is a material change. By statute, any increase in death benefits is a material change, unless it comes from what are called "necessary premiums" or from interest or dividends under a contract for which no more than the necessary premiums have been paid. The necessary premiums thus referred to are new creatures of this statute, and essentially are defined in the legislative history as the premiums needed to provide level death benefits, at the lowest level in the first seven years of the contract, until the contract's maturity. The Section 7702 interest and mortality assumptions, etc., are used in calculating these premiums. For guideline premium test contracts, the necessary premiums are basically the guideline premiums. The Option 2 increases here are taken into account in computing the necessary premiums. For contracts operating under the cash value accumulation test, the situation is more complex. Basically, the necessary premiums replicate the guideline premium test limits with a 4% interest assumption.

4. If there is a material change, or an exchange of a contract (which is defined as a material change), the seven-pay test will be applied in a special way for the ensuing seven years, using a "roll-over" rule. The roll-over rule is basically a creature of 7702A's legislative history and tells us to reduce the ensuing seven-pay premiums (whatever they may have been without the pre-existing cash value) by taking the pre-existing cash value and spreading it over those ensuing seven-pay premiums in a special way. It's a way of giving credit, on a rateable basis, for the prior cash value as a means of paying up the future benefits under the contract. Specifically, you take the cash value and multiply it by a fraction, the numerator of which is the new full seven-pay premium for the materially changed contract, and the denominator is the net single premium, computed following the rules of the seven-pay test. That may cause the seven-pay premiums to go to zero for the next seven years. So, for example, if an option switch in a universal life contract was a material change, you could find that you can't have any more premiums paid under that contract for the next seven years. That's the way the statute is set up. What happens if the seven-pay limit goes negative? Do we have a modified endowment? The Senate legislative history says no; the Conference report on the statute was silent. We are looking for clarification from Capitol Hill on that question.

5. There is a lot more we could say in the material change area. One question has come up that is worth mentioning: Can you take a grandfathered contract (pre-June 21, 1988), including a single premium contract, do a Section 1035 exchange rolling that contract over into a new contract that is technically subject to Section 7702A (even a new single premium contract), and still preserve its old treatment and not have an MEC? I think the answer is yes, you can, because the roll-over rule will apply in that situation. There is a debate ensuing within the industry (possibly even a fight) over this question between people who are trying to protect old blocks of business and people who want new blocks of business manufactured out of old blocks of business. Nevertheless, I think that the way the statute is written, the exchange alone will not cause the new contract to become an MEC, because, as I say, the roll-over rule does apply.

I want to talk to you about the new Section 7702 mortality and expense limits. The industry opposed any change to Section 7702, while the Joint Committee stubbornly insisted that something had to be done to preclude perceived tax abuse, whether it worked or not, and that's what Congress enacted. Section 7702(c)(3)(B) was changed to say that the mortality and expense charges taken into account under Section 7702's tests could not exceed certain limits. The problem came in trying to say what those limits were. The industry had previously done some struggling to try to suggest some meaningful limits, but the industry could not figure out what those limits ought to be to make them completely equitable among all companies.

So there was no industry guidance, and the statute shows that. The new limit says the mortality charge used in the Section 7702 calculations must be reasonable as defined under regulations (we don't have regulations yet -- we probably will early next year) and must not exceed certain charges stated in the valuation tables used for tax reserves (apples and oranges, in other words) unadjusted for substandard risks. We hope to get regulations early next year defining what all

this means. That doesn't do you much good now. The ACLI is working on getting input into the IRS and Treasury.

However, we do have two interim rules which are of some help. One is IRS Notice 88-128, which says that you may assume that 100% of 1980 CSO table charges are reasonable until further notice. Well, you may think you know what the 1980 CSO table is -- maybe you do and maybe you don't. If you are planning to use unisex charges for contracts other than those issued in Massachusetts and Montana, you don't have the right to do that under this notice. The IRS has been asked to clarify that so you can use unisex charges elsewhere, because in some instances you are compelled to do so, but that is still left unclear. What do you do with smoker/non-smoker differentiated charges? I think you can probably use them, but I'm not sure that those are based on prevailing 1980 CSO tables within the meaning of Section 807 of the Code (which is required by cross reference to be the standard). Also, if you charge substandard charges, you can use those (even if they go beyond 100% of CSO), but only if you have an underwriting record. If you don't, such as for a simplified issue case, I don't know if you have the right to use more than 100% of the 1980 CSO, even if you do charge substandard rates. Also, for substandard cases, do you have the right to build some redundancy in the charges, or must they be more or less what you are going to use in the future? Well, I don't know the answer to that either, but closer to actually "dead on" is where the statute is.

The expense charge situation under the Section 7702 amendments is virtually hopeless, especially where there is expense flexibility in the contract. The statute says that the charges must be reasonable, and reasonably expected to be actually paid to be reflected in the Section 7702 calculations. If you don't have expense flexibility in your contract, you are better off as the result. You are better off fixing an expense charge at the moment, until we get regulations, and sticking with that in your contract and the way it operates in the 7702 calculations.

Is all this complexity worth it? I don't know. I get rather tired of hearing people say that all of this is the full employment act for actuaries and lawyers and accountants. It's a waste of productivity, and I hope that the industry will take that into account the next time it has the opportunity to weigh maintaining tax benefits against taking on added complexity. At some point that is going to break down, the scale will tip, and we will all go crashing down with it.

MR. RICHARD C. KLEIN: I've been asked to discuss the actuarial concerns of two separate topics: living benefits and guaranteed features in today's designs. I'm going to spend most of my time on living benefits -- long-term care riders in particular -- and end with some overview remarks on the implications of guaranteeing recent universal life bonus-type enhancements.

I'm going to devote most of my living benefit time to long-term-care (LTC) riders for two reasons. First, long-term-care riders are a life insurance enhancement which addresses a real need in this country, and I'm not sure you can say that (at least not with the same degree of conviction) with respect to other types of living benefits. Second, my company -- First Penn-Pacific -- has been marketing an LTC rider for more than a year now, and I think we've learned some lessons that may be valuable to companies that are just beginning to develop the coverage.

I expect that many of you have been asked by your company management to undertake development of an LTC rider. I'd like to discuss four areas that should be of concern to you in this project: marketing, benefit design, pricing, and taxation. I won't discuss state filing and approvals, except to say that we're approved in 31 states of 43 filed, and we could probably go back and get approval in two or three of the other states if we tried again.

LIVING BENEFITS

The basic idea behind living benefits can be stated pretty simply. When someone is in good health, the economic value of a life insurance policy covering his or her life is the cash surrender value. If the insured's health is impaired, however, the economic value of the policy is higher than its surrender value. In the extreme, if the insured is in very poor health and is expected to die in a short period of time, the economic value is close to the death benefit. Living benefits provide a way for the policyowner to "cash in" this higher economic value before death to pay the large bills that often accompany seriously impaired health.

Long-term care is one such "large bill." The average monthly cost of long-term care is about $2,000 today, and it's rising rapidly. Medical technology keeps improving, people keep living

longer, and the expected cost of long-term-care keeps rising. Medicare doesn't pay for it. Post-retirement health care provided by employers doesn't pay for it. Medicaid does pay for it, but only after the person's assets have been "spent down," that is, after the person has become impoverished. People are looking for solutions.

One popular solution is a stand-alone LTC health policy, and these are rapidly growing in popularity. Another solution is an LTC rider on a life insurance policy. The first such rider to appear was National Travelers' the second was First Penn-Pacific's, and the third was ITT Life's. National Travelers' rider and ours were developed independently, and we were both quite surprised when we became aware of the other. We filed ours in November of 1987, a couple of months behind National Travelers. Sales began to materialize in the second quarter of 1988.

I haven't traced the idea back to its roots. I believe it was being discussed in various companies a few years before the National Travelers' contract appeared. The time was ripe for the idea, because LTC was emerging as a critical need with inadequate solutions. In our company it was being discussed at least a year before we decided to move on it. The concept fit well with our corporate mission -- we're a subsidiary of Lincoln National, and part of our role within Lincoln is to try new ideas.

Marketing

Our main reason for developing the product was very simple -- to sell more life insurance. We didn't intend for it to be a big profit source directly, but indirectly, by expanding our life sales. We saw this expansion occurring in three ways: 1) by substituting First Penn life sales for other companies' life sales; 2) by creating new opportunities for life insurance to be sold; and 3) by attracting new quality producers to the company.

In a nutshell, all of the above happened, but none of it happened as fast as we believed it would. The learning curve turned out to be a lot longer than we thought. We're still learning. The most important advice I can give a company just starting to market the product is this -- don't expect miracles.

We're now very pleased with what the product, which we market under the name Assured Care, has done for us. In states where the rider is approved, we're currently attaching it to 40% of our individual life sales. That's a pretty remarkable figure. Also, some distributional opportunities have opened up for us because we're one of very few companies offering the coverage at low cost.

Now, of course, most of the 40% are sales that would have been made anyway. Because the rider adds little to cost it's an attractive option to a life sale, similar to, but more attractive than, say, waiver of premium or accidental death benefit (ADB). However, we're convinced that some of the 40% are sales that would not have been made by First Penn and some are sales that would not have been made by any life insurance company.

I'd like to relate some of our thinking as it's evolved over the year that we've been actively marketing the rider.

When we first introduced the rider, we expected that the most promising market would be prime-lifers. These are people between the ages of 45 and 65 who are beginning to think about retirement. People in this age range gain a first-hand knowledge of the LTC risk by arranging for their parents' care, or from observing friends who've had to do so. They know how expensive it can be. They would like to make sure that they will be able to afford their own LTC when their time comes.

But prime-lifers are too young to have any interest in a typical LTC health policy. The risk of their own confinement is still minuscule and will be very small for years to come. Because LTC policies provide no cash values, it's considered a waste to buy one at their age. Also, for all they know, maybe the government will pay for LTC by the time they need it. But they don't want to take the chance.

Prime-lifers are still young enough to need life insurance, however. We reasoned that a life policy that also provides for the LTC risk would be attractive to them, provided it did so at little extra cost. If they could buy our life policy for roughly the same overall cost as the next company's policy, but ours provided this important additional coverage, we would have a distinct advantage.

We felt that keeping the additional cost small was important. If we charged too much extra, we thought we might miss this prime life market entirely. Just as prime-lifers are not willing to buy LTC health policies, they would not be willing to buy an extra expensive life policy just because it also provided the LTC benefit.

We therefore designed a very low cost benefit. The elimination period is 6 months. Thereafter, it pays a monthly benefit of 2% of the net amount at risk, with the net amount at risk calculated at the end of the elimination period. During the benefit period the life insurance monthly deductions continue -- there is no built-in waiver benefit. Also, there is no home care benefit. Each payment reduces the remaining death benefit.

Our charge for the benefit is 5% of the monthly cost of insurance charge for life insurance. The additional level premium required to provide the benefit turns out to be 2-3% of the premium otherwise needed. Even with the LTC benefit added on, our policy competes favorably with ordinary universal life policies and, we reasoned, would be attractive to prime-lifers.

The rider's 40% penetration proves, I think, that we have successfully appealed to the prime life market. Some statistics I'll show you later demonstrate this.

In addition to prime-lifers, we saw a second market for the benefit -- older age single premium sales. You're all familiar with this market. These are sales made primarily for investment purposes, with an emphasis on maximizing rate of return and minimizing the insurance element. This market has been quite important to First Penn in recent years. In our case, most of these sales have been made by financial planners. The typical age has been quite high, somewhere in the 60s.

We felt that Assured Care would be a natural in this upper age single premium market. The sale would still be made for tax-advantaged investment purposes but would now offer something extra that was of real importance in this upper age market. Having "something extra" is now particularly important, given that some of the tax advantages of single premium have been eliminated by TAMRA 88.

Unlike many other companies, the single premium market has remained very important to us, and we attribute this entirely to Assured Care. Assured Care provides a new reason to invest in universal life, and in our opinion, it more than makes up for the recently lost tax advantages.

We're convinced that some of these single premium sales would not have been life insurance sales without Assured Care. These sales are being made by financial planners to retired people who can reposition emergency funds. By emergency funds I mean assets which are not needed to produce current income -- assets which, except for some emergency, would be left to grow and eventually be passed on to heirs.

Because of the death benefit and stepped-up cost basis at death, single premium life has many attractive features for these people. The hitch has always been: "What if I need the money first to cover an emergency?" If you ask "What emergency?" the answer is usually "Long term care." For these people, Assured Care eliminates that concern. Not only does it make the original investment available, it also makes the death benefit available to cover LTC costs.

Very frequently in these single premium sales, we're now finding that the life insurance is not being minimized. Instead of the sale being strictly an investment, we're selling more face amount and, therefore, making a larger profit margin than we formerly did.

Some examples follow that show characteristics of the business we're writing.

Because of the large amount of single premium business, there is a much different age distribution by premium than by policy count. The distribution by count is close to evenly split between those younger than 60 and those older than 60. This distribution is somewhat distorted because it contains some employer-sponsored payroll deduction business, which has a younger age distribution than regular business. But, even allowing for this, it's clear that the prime-life market is providing a significant proportion of our sales.

With regard to the economic importance of the single premium sales, more than 85% of first-year annualized premium comes from ages 61 and over, and more than 40% comes from ages 71 and over. Our maximum issue age is 75, but we do make exceptions for single premium sales up to age 80.

As a side comment on the single premium business, I'd like to say that I believe it's a profitable type of sale. Our persistency has always been good on this business, but with Assured Care it should be even better. Now it's more than an investment sale. If bank CDs are crediting higher interest than the universal life policy a few years after the sale, we stand a much better chance of hanging on to the customer if he's relying on it for his LTC needs.

Some policies are coded in our system as single premium, i.e., no premium notices are to be sent. Again, there is a predominance of single premium at the higher ages. We tend to be a fairly low face amount company. The average face amounts above age 40 are roughly constant at 90,000. The average first-year annualized premium, rises sharply with age. This reflects the higher percentage of single premium sales at the older ages. It also reflects the fact that the average single premium gets larger as age rises.

Product Features
I'd like to turn now to product design. I don't have the time to survey each possible feature, but I'd like to discuss certain key decisions in product design, describe the choices we made a year and a half ago at First Penn, and conjecture whether we'd make the same choices today.

In-force Requirement
Many companies require the rider to be in force for a minimum period before the benefit takes effect. Frequently, the requirement only applies to sickness; accidents are covered immediately.

Since the policy is underwritten as a life insurance policy and is therefore subject to much more stringent underwriting than LTC health policies, it never occurred to us to include one. We feel these requirements are unnecessary.

Elimination Period
We chose 6 months in order to minimize the cost of the rider. Most other companies have chosen a shorter period -- the most common choice is 90 days.

We get more negative comments about the 6-month elimination period than about any other feature. Still, it hasn't been a serious problem. When the issue comes up, our first response is that the longer elimination period enables us to offer a cheaper rider. Our second is that the policyowner can withdraw cash value during the first 6 months, if he needs to, to help pay the bills. The way our contract is structured, such a withdrawal won't reduce the later benefit payments, which are based on net amount at risk.

I haven't attempted to estimate the difference in cost between a 90-day elimination period and the 6-month elimination period. If I were to do so and present the results within the company, the consensus might be to choose the lower elimination period, despite the higher cost.

Benefit Formula
The benefit formula we chose pays 2% of the net amount at risk measured at the end of the elimination period, up to a maximum of $3,000 per month. In addition, we'll distribute cash value at whatever rate the policyowner requests, but our "default" is to make level monthly distributions of 2% of whatever the cash value was at the end of the elimination period.

There is an emphasis on equity in this formula. The benefit payments -- the 2% of the net amount at risk payments -- reduce the remaining death benefit, but they do not reduce the cash value. They are truly "benefits" -- an enhancement of policy benefits added by the LTC rider.

The cash value distribution payments are not benefits added by the rider. The base policy gives the policyowner the right to withdraw cash value, so the LTC rider adds nothing in this regard. When we drafted the rider, we felt this distinction between "benefits" and "cash value distributions" was very important. We didn't want to call something a rider benefit that was already there in the base policy. In retrospect, I don't know if this degree of caution was necessary, but we wouldn't do it any differently today.

Our charges for the benefit are based on the net amount at risk, i.e., on the amount of the total potential benefit payment. For example, if the policy has a $100,000 death benefit and a $90,000 cash value, our charge for the rider is based only on $10,000.

Other companies have developed contracts with formulas such as "2% of the first $150,000 plus .5% of the excess of $150,000." These two-part formulas attempt to limit LTC overinsurance while, at the same time, still providing some additional contribution to the LTC benefit from larger face amounts. Doing it over again, we would probably incorporate this kind of formula. We would base our charges for the rider on the same formula.

The overall benefit amount limit of $3,000, hardcoded in the rider, is unfortunate. Doing it over again, we'd put in some kind of inflation feature to keep this limit up to date, perhaps letting it increase 5% per policy year, or, more difficult, letting it inflate per some cost index. We feel, however, that we could allow this item to increase as an administrative practice, regardless of form language.

Adjustment Mechanism
The adjustment mechanism refers to just how you reduce the remaining death benefits and cash values when you pay LTC benefits. Our approach is to reduce the specified amount by the amount of the benefit payments (the net amount at risk part) and to process the cash value distributions as partial surrenders. The benefit payments themselves do not reduce the cash value. If the 2% cash value distributions are paid, the death benefit and cash values are reduced proportionately. This approach might be called the benefit-reduction, partial-surrender approach.

There's an alternative approach which involves the attaching of a permanent lien against the death benefit and cash values of the policy. The LTC payments are "loaned" to the policyowner just as if they were a policy loan, but with two differences. First, the loan is non-interest-bearing. Second, it isn't limited to the surrender value. As with normal policy loans, it's paid back upon death or surrender by means of the lien.

We considered the lien approach when we developed our rider, but opted instead for the benefit-reduction, partial-surrender mechanism. The lien approach seemed to work fine if the insured never recovers. But if he does, he finds that all the LTC benefit payments he received came from his cash value. He might well question what was the good of having the rider, and paying additional premiums for it, since he could have borrowed or withdrawn his cash value without it.

In fairness to the lien approach, I believe some companies have structured the lien so that it only applies partially against the cash value.

Maximum Lifetime Benefit
Some LTC riders will only pay out a portion of the death benefit through LTC payments, such as 48% (2% per month for 24 months). We'll pay as much as 100%, and we feel there may be a marketing advantage in being able to say so.

Home Care
Most forms being developed today cover some degree of home care. I've not attempted to design and price such a feature, and I'm not sure I want to. I say this because the cost for a meaningful benefit could be high, and as I've said, we want to keep the cost of the rider low.

With a home care benefit, you're straying from the "prepayment of the death benefit" concept and making the package significantly more expensive. The issue does come up, but we don't feel we've suffered any real disadvantage from not having one. This could change, though, as more companies enter the market with home care, and as more stand-alone health contracts offer it.

Waiver of Cost of Insurance (COI)
Based on my pricing, this benefit adds significantly to cost because it's an additional payment rather than a prepayment. We doubt if it's appreciated in proportion to what it costs. Hindsight tells us we were right to leave it out.

PRICING ISSUES
When it comes to pricing, life insurance actuaries are pretty spoiled. Pricing assumptions can be specified fairly accurately, and the programs we use perform very sophisticated calculations to

measure profits. It's been said, not altogether facetiously, that the biggest pricing risk in life insurance comes -- not from bad experience assumptions -- but from undiscovered bugs in our sophisticated programs.

Health actuaries don't have it so good. They deal with risks less predictable than mortality. When they have to price a new benefit, as they frequently do, it doesn't traumatize them to engage in a little seat-of-the-pants pricing. Most LTC riders call for some seat-of-the-pants pricing.

In thinking about pricing these riders, it's helpful to separate costs into two basic categories: 1) paying dollars you would have paid anyway, but paying them sooner, and 2) paying additional dollars.

The first category, paying the same dollars sooner, refers to prepaying a death benefit that you would have paid anyway, i.e., whether the rider was there or not. The real cost here is forgone interest.

The second category, paying additional dollars, refers to paying dollars that you would not have otherwise paid. I would include waiver of COI charges in this category. Most riders waive the life insurance COI charges while the insured is receiving the LTC benefit. In the absence of the rider, the company would have gone on receiving the COI charges. Here the rider is costing more than interest -- it is causing COI revenue to be forgone.

The expense of administering the LTC claim belongs in the "additional dollar" category. Normally, you'd think this would be a rather insignificant item. However, I've seen pricing where the expense assumption was 9% of claims plus $10 per check. This means it costs $190 per month to pay a $2,000 per month benefit. The $190 represents "additional dollars" whereas the $2,000 is offset by $2,000 less death benefit paid later on. Expense of this magnitude can be significant in the final cost of the benefit.

There is another less obvious type of "additional dollars" cost. You can pay an LTC claim on someone who fully recovers his health and later lapses or surrenders the policy. If the rider had not been there, the insured, presumably, would still have incurred the LTC costs and, presumably, would have still gone on and lapsed or surrendered the policy. Unless the rider is of the "full lien" type with sufficient cash value, the LTC claim represents some "additional dollars" cost. The importance of this "additional dollars" expense is much smaller with long elimination periods. If the rider has a 6-month elimination period, I believe this factor would be negligible. If someone has been confined for more than 6 months and is then released, it's very likely that his or her health is quite poor and, therefore, he or she would not surrender the life insurance or allow it to lapse.

In pricing an LTC rider, there are certain seat-of-the-pants assumptions that must be made:

1. The incidence and severity of LTC confinement. If the company has been selling LTC insurance for a number of years, it may have sufficient company data to use in pricing. Most companies do not, however, and must rely on published data. The SOA does not, as yet, collect and publish LTC data.

   The largest body of government data is the 1985 National Nursing Home Survey, published by the National Center For Health Statistics. Unfortunately, this body of data is flawed for insurance purposes. First, it's based on uninsured lives. Second, the definition of a period of confinement does not correspond with the definition within an insurance policy. For pricing purposes, the Survey overstates incidence rates and understates length of stay.

2. Data on the utilization of home health care. A major concern with respect to home health care is that of induced demand, where the existence of the benefit causes its utilization. This is also a concern, but relatively less so, with the confinement benefit. Nursing homes are not, as a rule, pleasant places to live, and insureds would prefer to live at home if they could. Therefore, there is a built-in disincentive to use the confinement benefit. This is not true with home health care.

3. Mortality while receiving LTC benefits. This is a key assumption, and to my knowledge, no data on it exist. It is a key assumption because it greatly affects the cost of the prepayment benefit, that is, the "same dollars sooner" element.

Remember, the death benefit is reduced as LTC benefits are paid. Imagine an extreme case, where LTC mortality is so high that everyone dies a month after entering the nursing home. If this were the case, the LTC benefit would add virtually nothing to the cost of the life insurance policy. You would be losing interest on a very small part of the death benefit you'd pay anyway. For example, instead of paying $100,000 in month 2, you'd be paying $2,000 in month 1 and $98,000 in month 2. And you'd be doing this only for those who were confined in a nursing home before death.

The other extreme is where the mortality of those confined is no worse than the mortality of those not confined. If this were the case, the forgone interest on prepaid benefits would be substantial. In addition, there would be a much more significant "additional dollars" cost because those who recover would not be in poor health.

Another factor to consider in pricing the benefit is underwriting. The underwriting that's done on a life policy with an LTC rider is essentially life insurance underwriting, with special attention paid to certain conditions which increase the LTC risk. Life insurance underwriting is much more stringent than the underwriting generally done on stand-alone LTC health policies.

Even though pricing the LTC rider is more problematical than pricing life insurance alone, there is, fortunately, an overall reasonableness check that can be employed. A life insurance policy with an LTC rider should generally be significantly less expensive than purchasing a life policy with a separate stand-alone LTC health policy. The former combo pays LTC benefits instead of life benefits, the latter pays them in addition to life benefits. In addition the latter offers commission and issue expense savings.

There should be a substantial economy from the LTC rider. However, I've seen examples where there is only a small economy, or none at all.

Taxation

You shouldn't undertake the development of an LTC rider unless you're willing to live with some tax uncertainty. Currently, there are many unsettled issues, and it's not likely that they'll be settled anytime soon.

It should be emphasized, however, that the LTC rider is not a tax shelter device. It diminishes investment performance, rather than enhances it. There is no intent to expand the tax advantages of life insurance, only to add a socially desirable enhancement to life insurance without losing the tax advantages that already exist.

Here are the major issues:

1. May the LTC benefits paid under the rider be excluded from taxable income as personal health insurance benefits under Section 104?

   This has been an unsettled issue for stand-alone LTC health policies, and it is now also an unsettled issue for LTC riders. A recent revenue ruling (89-43) clouded the issue further. The ruling did not concern itself with policyholder taxation. It concerned the treatment for company taxation of LTC active life reserves. However, the ruling seemed to go out of its way to warn the industry that it shouldn't assume that LTC benefits are excludable.

   It is reasonable to assume that LTC benefits provided by LTC riders would be treated the same as LTC benefits from stand-alone health policies. But, as in most every tax issue surrounding these riders, one cannot say this with certainty.

2. Is there any danger that the attachment of the rider could jeopardize the life policy's status as life insurance?

   It seems very unlikely that the LTC rider could disqualify the policy, but, under existing law, one cannot say with complete certainty.

3. May the charges for the LTC rider increase the guideline premium limitation?

   Since the benefit is not on 7702's list of qualified additional benefits, its charges may not be taken into account in calculating guideline premiums. The industry may ask that they be added to the list by regulation.

4. Should the monthly charges for the LTC rider be deducted from the tax basis of the contract? Could they be considered distributions from the life contract?

   Because the benefit is not a qualified additional benefit per 7702, it is possible the IRS could rule its premiums (monthly charges) should be deducted from basis. It is even possible they could take this position for qualified additional benefits as well. Even though no cash is received, one cannot say with certainty that the charges would not be considered distributions.

5. Are adjustment computations under Section 7702(f)(7)(A) required when payment of the LTC benefits reduce the remaining death benefit?

   Under current law they would seem to be required.

All of these problems and uncertainties can be made to disappear with the stroke of a pen -- the President's pen on an LTC bill. We believe that a legislative solution is the best way to gain favorable tax treatment for LTC riders, and we intend to work with the ACLI and other interested parties to get appropriate provisions added to an LTC bill. Because LTC is widely recognized as a problem requiring solution and is getting a lot of attention in Congress, we are optimistic.

MR. THOMAS E. NORTON: I have two questions for Mr. Adney. The first question is, on the sixty day return feature, has there been any discussion on variable products in cases where there may have been a loss during that period? I guess the first question has two parts -- whether it's appropriate to return premiums and then assess the loss; and secondly, does that make you clean with the premium amount you took out? Next, when you talked about material change, it was always my perception that if, on a cash accumulation product, you set it up with a premium-to-face ratio (when that premium was a seven-pay premium) and you made all seven premiums, but favorable experience kicked up your death benefit, that was still a clean contract.

MR. ADNEY: First of all, yes, I think there has been discussion of the treatment of variable life insurance (VLI) under the 60-day premium return rule. No, I don't think the discussion answered much of anything. Let me elaborate. I think the discussion has been within the industry, and not thus far with anybody in the government. I think we will see some elaboration about the 60-day rule in general, particularly as it's phrased under Section 7702, but that pretty much carries over into Section 7702A. When the IRS gets around to issuing regulations (in temporary and proposed form -- hopefully early in 1990), I think there will be an opportunity for the industry to make input on how VLI should be covered, but without that input, I don't know that VLI will be adequately covered.

Let me answer the way I think the 60-day rule works in general, and then specifically for VLI. Generally, I think the rule stands for the proposition that you'd be making some kind of a premium return (which would be not a taxable premium return), and then you would need to credit interest; that's what the statute says, "interest" on that amount. However, the statute doesn't say how much interest. There are several possibilities, but I think in order to claim the protection of the 60-day rule, you'd best look at the highest rate of interest being credited under the contract for the period in which there has been "overpayment" of the premium.

For VLI, it gets a lot more problematic, particularly in the loss situation. From the face of the statute, what you are required to do, even in a loss situation, is return the overpaid premium (even if you had lost it in the investments) and return some reasonable rate of interest (even though the amount is running a loss).

Now you can hope that when regulations come out, with industry input, this will be clarified; and if any companies are specifically interested in this, they should write their own letter to the IRS and ask them to include it. You can hope that you'll be given credit for the negatives and

basically not have to pay out money that has been lost, and to be able to say that you complied with the interest requirement, even though when you have paid out what you can, there has been a negative return under the contract. It is a fuzzy area, very much up in the air.

As far as the material change rule is concerned on the cash value accumulation test, I think you are right that what you would be doing is calculating your seven-pay premiums, whatever those happen to be (whatever you can get in under the door). In order to make that calculation, you will generally be using leveled-out benefits, and then if you carry that over, I think you would have not collected more than the necessary premium. If that is so, then any dividends, excess interest, or mortality charge reductions (or whatever causes your death benefit to go up) are not going to cause a material change.

I think your approach is the correct one in that you are trying to approach it negatively by a process of elimination, and that is the right way to approach it under the cash value accumulation test. The big question is in dealing with the sloppy way that the test was described and the necessary premium defined in the House Committee Report under TAMRA. There are references in there to expense charges. Well, Congress ignored the fact that there are no expense charges under the cash value test; and also that for contracts subject to the cash value test, you may not be showing expense charges. For universal life-type contracts, you'll have less of a problem.

There are rough edges in there, but I agree with your approach, and that is what the regulations ought to say if they are ever written to confirm it.

MR. ABRAHAM S. GOOTZEIT: The one area that I feel needs additional clarification has to do with the design of the monthly benefit return of the net amount at risk. It seems at the older ages (when most of these products are single premium) the automatic benefit (being 2% of the net amount at risk) comes a point when the corridor percentage will not allow you to reduce the actual death benefit any more. Now you could do something with the specified amount, but it seems that you do get into the prospect of paying out additional benefits. As a rough example: if at age 70 you have a $90,000 death benefit with $30,000 of cash value, there comes a point when you cannot reduce the net amount of risk much below the $90,000 (because the corridor kicks in). I'm rather curious if you have priced for those additional new benefits when you came up with the charges for the LTC rider.

MR. KLEIN: No, we didn't Abe. The corridor and the guideline adjustments on decreases in benefits are very troublesome when you are paying out benefits. Our default is to distribute the cash value in the same proportion (2% of the cash value at the same time we are paying 2% of the net amount at risk). So the cash value and the net amount at risk go down in the same proportion, and if you weren't in the corridor before, you won't hit it, unless the insured instructs us to keep the cash value and just pay the benefit. Because of this problem, we don't intend to ask the insured whether he wants the cash value paid -- we're just going to pay it.

Let me make a comment about the tax situation in general, and I look at this as a subset of the tax situation. I think the solution is legislative rather than asking the IRS to give us a break on these things. When 7702(b)(7)(A) was designed, the IRS didn't have in mind benefit reductions caused by paying LTC benefits. It may be reasonable to ask the IRS not to apply the corridor and guideline premium adjustments in this case. However, I wouldn't want to ask it that because it might say "yes." I think a legislative solution is the answer to this and other tax problems, and at First Penn we're going to work with the ACLI, and other interested parties, to see if we can get the tax problems cleared up.

MR. PAUL D. REEDER*: I'd like to follow up on a comment that Mr. Adney made concerning Section 1035 exchanges that they would qualify for the recalculation formula. Does that apply to increases, decreases, and like amount exchanges equally? If it does apply to decreases, is that a loophole in the law so that you could, rather than reduce a policy and have a retroactive recalculation of seven-pay premiums, do a Section 1035 exchange into a new policy for smaller amounts and avoid that?

* Mr. Reeder, not a member of the Society, is an Assistant Actuary in Product Development at Beneficial Life Insurance Company in Salt Lake City, Utah.

MR. ADNEY: I think that any of the exchanges (probably including an exchange of a grandfather contract) is a material change, and therefore the rollover rule will apply. I think that will be the case whether you are talking about an increase, the same face, or a decrease. Obviously, the same face or an increase makes the most sympathetic case. If you go in with a decrease (I'm going to talk about the first seven years in a minute), it sounds less sympathetic; but if the old contract had been there for 20 years, the simple fact is that, consistent with Section 7702A (whether it makes any sense or not), you could reduce the death benefit without causing a material change or any further testing. Therefore, I think it is consistent to say that even decreases will not cause a problem. You'll still be treating those as material changes (because they are exchanges), and the roll-over rule still applies.

Now is that a loophole? Well, the House drafters were already there. They thought about that loophole, and they put a footnote in the House legislative history which was adopted, by osmosis, by the Senate. (The way the process works is that anything said in any preceding report that was not specifically contradicted in a later report is considered valid legislative history behind the statute.) The House report said that you cannot use the exchange approach to get out of the seven year reduction rule. As an example, let's say you had a contract for $100,000 of face amount for five years, and then you reduced it to $50,000; at that point you trigger a recomputation under the reduction rule. From day one it is considered to be $50,000. Could you do a Section 1035 exchange in the fifth year to a lower face contract, use the rollover rule and avoid the problem? No. The seven-year rule will follow you around. I'm not sure exactly how the IRS is ever going to track this, but theoretically at least, during the first seven years (starting from the date of the issuance of the original contract, or any material change in that contract) you will need to watch for the reduction, and you could trigger the retroactive recomputation. What I think that would mean in the context of the rollover is that you wind up with different values on the rollover event.

I don't think there will be an abuse, because if the legislative history is followed, it has already solved the abuse by continuing the application of the reduction rule. But I still think your comment is valid beyond the legislative history -- that is if you push too hard on the use of the rollover rule and exchanges, coupled with decreases (particularly if you are dealing with old, grandfathered coverages to be rolled over), to a degree you are going to challenge the IRS to ask whether that is fully appropriate. As I said, I think the IRS can easily reason that it is fully appropriate, but it will have some glimmering around the edges of looking like the promotion of single premium sales, and it may very well make the IRS uncomfortable.

MR. GLENN A. TOBLEMAN: This is probably directed mostly at Mr. Adney and Mr. Klein. Under Section 7702, there obviously is no mention of LTC riders as being a QAB. I'd like to know what your position is on that, and if the answer is negative, is there any attempt by the SOA to get that issue addressed by the Congress?

MR. KLEIN: I'll speak for First Penn Pacific. LTC riders are not on the list of QABs. It hasn't been added by regulations, so we feel you cannot take the charges for it into account in calculating the guideline premium limitation, and we don't.

MR. ADNEY: I agree with Rich. There is an effort being made in the ACLI to get the LTC inside buildup, but the IRS has expressed great skepticism and negativism, as you would expect it would, at allowing such a thing. They recently revoked a letter ruling that was issued to a whose policy had an inside buildup. The IRS had originally said it was tax deferred, and now that is not true. So, I think the QAB approach, while it has some attraction, has a tough row to hoe. The ACLI is doing its best to work to get that done.

MS. ELIZABETH S. BRANAUM: I have a question for Mr. Adney about paid-up addition riders regarding the seven-pay test. Is there any way to assure that if you have a paid-up addition rider, you will always comply with the seven-pay test? Is there any way you can build the rider so that you will know you comply, and your policy won't be a modified endowment?

MR. ADNEY: I don't know that there is. The Senate legislative history said that the rider is part of the base contract for purposes of the seven-pay test. Therefore, the premiums you pay for the rider, and the benefits under the rider, are both taken into account under the seven-pay test.

On the other hand, you've got two other things that you need to worry about. First, the seven-pay limit has to be computed assuming that the lowest benefit is the one that is extended on out into the future. So what that essentially is going to do is limit how much of the future benefits (under that paid-up addition rider) could be purchased to be taken into account for the seven-pay limit. It is going to establish a limit that is artificially low at the start.

Secondly, you have the necessary premiums sitting in there, and the IRS is even more narrow-minded (it view all contracts as basically level contracts for the lowest benefit in the first seven years. If you pay in more than the necessary premiums, even if it's within the seven-pay limit, you will be setting yourself up for a future material change which could produce nasty consequences. In fact, it probably will produce modified endowment treatment under the "clawback" rule of the Conference report, which takes any unnecessary premium and eventually matches it against a zero seven-pay limit in the future, creating a modified endowment.

So the answer is that there isn't a way to assure it, particularly in the design of the contract. I think what you've got to do, if I understand these things correctly, is set up a system, and put out illustrations consistent with the system, telling the policyholder he can keep on paying, but there is going to come a point when he can't pay anymore. At that point, send him a notice saying congratulations, you fully paid up your contract. That is the nature of this thing, simply because what you have is essentially an increasing feature that is premium driven, and that's the very kind of thing the test is set up to cut off at some point.