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ACCELERATED DEATH BENEFIT RIDERS

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- Current product structures
- Consumer response
- State insurance department reactions
- Tax issues
- Anti-selection considerations

MR. ABRAHAM S. GOOTZEIT: We have a distinguished panel here. We have people who have actually done and implemented accelerated death benefit riders as opposed to those people who talk about doing these riders. This panel is quite distinct from some of the others that we have at the Society meetings.

We have a lot of problems with nomenclature. This session is entitled "Accelerated Death Benefit Riders." To a lot of people that might mean what I might commonly call, "Catastrophic Illness Riders." We intend for this session to be quite broader than that and have a number of different product types to discuss. The term we've been using lately is living benefit riders, and if we had the benefit of hindsight, we would see "living benefit riders" up here rather than "accelerated death benefits."

The panelists we have, as I mentioned, are quite good. Jim Gunderson is from Capital Holding. Capital Holding is a company that has pioneered terminal illness benefits in the United States that pay out part of the death benefit when a person is diagnosed as being terminally ill. Jim is an assistant vice president and a product actuary for individual life insurance.

Mike Smith is vice president and chief actuary of Provident Life & Accident. Mike's company has been instrumental in the development of a catastrophic illness benefit and Mike will be discussing that at some length as well.

I am a consultant with Tillinghast and after these guys are done with their discussion, I will talk about long-term-care riders. Before we start with the products themselves, I would like to go through an introduction about the riders and exactly what they do -- just general information about the riders which is common across the various types.

The basic design of these riders is really deceptively simple. There is a monthly benefit or single benefit depending upon the type of rider. It's based upon policy size. There's no individual selection for the advance of the life insurance proceeds. The riders we will be discussing actually advance the life insurance proceeds which are already on the table so there's a well-controlled financial risk profile that these products enjoy. Now all of the products have a variety of health insurance eligibility requirements which we will go into in some detail later. I prefer to use the term *gatekeeper*, but gatekeeper is not one of those words that has a lot of positive connotations to it. Through the discussion, you'll notice that we will be talking about health insurance a great deal. We should keep our eye on the primary emphasis of these products which is to sell more life insurance. As we go through you should keep that in mind. What we are trying to do is sell more life insurance with the use of these riders, and the secondary emphasis which we should keep in mind is simplicity. Modern life insurance policies have gotten extremely complicated, and we start putting these health insurance contingencies on top of them and they get more complicated yet. Where the two meet at the edge, we have a very complicated construction of how we advance out the benefits. So anytime you have an opportunity to develop one of these things, I think simplicity is very important.

Why have these products become successful? Do we have a receptive audience out there? I'm sure this has never happened to any of the companies you represent, but I've heard that there are companies out there which have 20-year cash values that are inadequate or slightly deficient compared to other 20-year cash values. Obviously, no one here represents one of those companies. There is a marketing advantage by having one of these riders on top and having a visible and desirable benefit that allows you to differentiate your product in a very crowded field of undifferentiated product offerings.

Let me identify the contingencies that we've seen so far. The first one is confinement in a long-term-care facility. The second health contingency which will trigger these advance payments is specified catastrophic illness or dread disease. The third one is a terminal illness with limited life expectancy and the last one is "other." Other includes things like Prudential Life of America in Canada which is buying its own policies up and charging the market rate of interest. It includes the company in New Mexico which is buying policies up for full satisfaction of the obligation at less than $100 and all sorts of other things we are trying to think of as we go through the expansion of this product line.

This is the conclusion of the overview section. Again, Jim Gunderson will talk about the terminal illness benefit with Capital Holding. Mike Smith will follow after that and talk about the catastrophic illness benefit with Provident Life & Accident. I'll come in to discuss long-term-care riders.

MR. JAMES E. GUNDERSON: I'm going to talk about "Living Payout Benefits," which a lot of people also call "Terminal Illness Benefits." A living payout benefit is an accelerated death benefit where the thing that triggers the early payment of the death benefit is a certification by the insured's doctor that the insured is terminally ill. Mechanically, a living payout benefit is a lot like the other accelerated death benefits -- it works the same way. But the marketing need that the living payout benefit addresses is a lot different from the need that the long-term care benefit addresses. For all practical purposes, I think of those as being two entirely different coverages. There are a lot more similarities between a living payout benefit and one of the dread disease benefits. As a matter of fact, in a lot of cases the sort of condition that would qualify a person for a dread disease benefit would also qualify him to receive the living payout benefit. When we decided at Capital Holding that we wanted to develop some sort of accelerated death benefit, probably the biggest decision we had to make to start off with was which of those two types of benefits we wanted to go with. We finally settled on the living payout benefit because we thought that it had a lot more marketing appeal, because of some marketing research that we had done. The marketing research showed that among the people who are likely to buy our policy, that was seen as providing a better value. There are also some other considerations to be made in choosing one or the other.

The first advantage of a living payout benefit is that it is totally unique right now. There's no other company with a product like ours, although there are a lot of other companies out there with dread disease benefits. The fact that it is unique gives our agents an advantage when they try to get into new houses. If an agent is trying to compete with agents from maybe a half dozen other insurance companies to get into a new household, the living payout benefit is something he can point to that he has and that nobody else has.

Another advantage of a living payout benefit is that it is really simple. In order to qualify for the benefit, you have to be diagnosed as terminally ill. We reserve the right to get a second opinion. If you decide to develop a dread disease benefit, the definition of the covered disease has to be written carefully enough so that you can properly handle it at the time of the claim and clearly show what's covered and what's not. Usually that requires a fairly long definition and a lot of medical terminology that the average lay person won't understand.

A third advantage of a living payout benefit is that it provides blanket coverage. You don't have to worry about becoming terminally ill with some disease that's not on the list of six dread diseases. This is really a big advantage if you consider the fact that you want to keep these policies in force for a long time and that 10 or 20 years from now, the diseases that people might be particularly afraid of may be quite a bit different from the diseases that people are worried about, because of medical advances and other reasons.

A final advantage of the living payout benefit is that it addresses something that is perceived by our policyholders as a real threat. They are worried about running out of money because of a prolonged terminal illness, either because of medical expenses or some other expenses. A living payout benefit addresses this fear directly. A dread disease benefit only addresses it indirectly.

There are also some disadvantages of a living payout benefit. One thing that we were particularly worried about was that we weren't really sure whether people would be willing to talk about terminal illness. We also weren't really sure whether people would be afraid that when the time came to receive the benefit, they would not be willing to have their doctors do the necessary certification. We did some market research that I talked about a little bit earlier that showed that most people, in spite of this fear, would still prefer the living payout benefit and would be willing to buy it rather than the dread disease benefit.

Another disadvantage of living payout is that it is hard to develop. Nobody else is doing it, or almost nobody else, so there's really no place where you can turn to for pricing information. You can't tell very easily how many people will elect the benefit. It's also hard to tell what sort of misdiagnosis rates and recovery rates you'll have. Those are important in your pricing. It's also hard to resolve a lot of design issues because you have very little else that you can turn to.

A third disadvantage is that if a product covers terminal illnesses only, it's not going to cover some diseases that are very serious but that are not terminal illnesses. You really can't be all things to all people and you have got to pick one or the other. We decided that there was more appeal from a benefit that addressed terminal illness rather than a benefit that addressed a list of six illnesses.

Now I would like to look at a couple of examples that show how a living payout benefit works. In the first example, we will look at a living payout benefit, which is mechanically very much like the dread disease benefit that you are used to seeing. The second example will have a twist that allows a living payout policy to cover an entirely different policy.

In the first example, John Doe buys a $50,000 life insurance policy on January 1, 1990 with a 50% living payout benefit; five years later, he's declared terminally ill. Half of the death benefit is paid to him in advance. The remaining part of the death benefit is paid to him a few months later when he dies. We also waived the premium on his policy from the time he was declared terminally ill. John got two things from that benefit. He got an early payment of the death benefit of the policy and he got the premium waiver.

Now, let's look at the other example. In this example, John bought a $50,000 life insurance policy ten years ago on January 1, 1980. On January 1, 1990, he bought a living payout policy that covered the other insurance policy. When he's declared terminally ill in 1995, the living payout policy pays him $25,000. A few months later when he dies, he receives a net payment from his other insurance policy of the remaining $25,000. We also waived the premium for his original insurance policy from the time he was declared terminally ill.

Let's take a look at how we did this now. When John was declared terminally ill, he called us to make a claim and we asked him to do a couple of things to his other policy. We had him assign the entire policy to us. He changed the beneficiary designation so we were named beneficiary for 50% of the death benefit. The other 50% of the death benefit kept the original beneficiary designation. We also became the premium payor of his other policy. There were two reasons why we did this: It was a benefit to John, since he no longer had to worry about paying the premiums once he was declared terminally ill. We also did it because we wanted to ensure that the coverage stayed in force so that, when he died, we would be able to recover our $25,000. When John dies several months later, the $50,000 policy that he bought 10 years ago has its benefits paid according to the current beneficiary designation: $25,000 goes to the company selling the living payout benefit, and $25,000 goes to the other beneficiary he named. Just as in the first example, what John got out of this was an early payment of $25,000, half of the death benefit, and the waiver of premium on the covered policy.

The second type of living payout benefit allows you to build in a lot of flexibility that you can't have with a living payout benefit that's attached to the policy it covers. This living payout policy covered one other policy in the example; but there's no reason why instead of covering a single $50,000 policy it couldn't cover two $25,000 policies or five $10,000 policies. It could cover

policies sold by other companies; it could cover a half dozen policies sold by a half dozen other companies. It could cover policies that have been in force for ten years. John could buy it to cover a policy he expects to buy three months from now.

Suppose a company wants to develop a living payout benefit or a living payout policy. What are some of the considerations that company needs to think through? The biggest issue is probably policyholder taxes. It's not clear how these benefits will be taxed. If you decide to develop one of these products, you probably need to bring your tax department into the work at some early stage. I think a lot of tax experts will agree that if you develop a living payout benefit like the one in the first example, where it covers its own base policy, the policyholder taxes are likely to be limited to the excess of the cash value of that policy over the premiums paid in. In the case of the second example we looked at, where the living payout policy covers another policy, I think most tax experts will agree that the benefit is not taxable.

Another issue that you have to consider is what you want to do with the coverage under the base policy once the living payout benefit is paid. If it's like the one in the first example, where it covered its own base policy, then the simplest thing to do is reduce the death benefit, the cash values and the maturity values in proportion to what was paid out. If it's like the living payout policy in the second example, you can't really do anything to that covered policy. It may be a contract that you're not even a party to -- but one thing you probably do want to do is figure out a way to make sure that the premiums for that policy will still be paid, so that you can keep it in force long enough to recover your death benefit.

A third issue to consider is whether you want living payout to cover term policies or just to cover permanent policies. If the living payout covers term policies, you have to consider the situation where the policyholder is declared terminally ill, then his policy expires and he dies after the term policy has expired. I think it would be possible to cover a policy like this, but your pricing would be somewhat different from a living payout policy that only covered permanent insurance.

The last issue to consider is the issue age range that you want to make this policy available for. The incidence rates grow fairly steeply with age -- so you will have to think through where you want to cut it off.

The underwriting for a living payout policy is likely to be very much like the underwriting for life insurance. The same risks that you worry about with terminal illness coverage are the ones you would worry about with death coverage. You probably would have to be more careful because you are likely to find more antiselection with a living payout policy than with a life policy. The real risk with one of these policies comes from the mistakes that you might make at the time of claim. If you pay a claim that you shouldn't have, because the insured is misdiagnosed and then recovers, you've lost the whole amount of living payout benefit. On the other hand, if you make a mistake at the time of underwriting, you pay the claim but recover it when the insured dies. You have really just lost the time value of money on that benefit and the cost of the premium waiver. The magnitude is much smaller.

Since this benefit is brand new, it's unclear what position a lot of the state insurance departments will take on it. I knew of five states that wouldn't approve a living payout policy. Those states are Minnesota, Illinois, Kansas, Oklahoma and Pennsylvania. I've since learned that New Jersey also is not approving this type of policy. We've filed one of our versions of the policy in about 25 states and got it approved. In a lot of the states we just don't know what their position is. We don't do business in New York, so, for example, I don't know what the New York Insurance Department's position on a living payout benefit is.

Now I would like to talk about Capital Holding's experience with the living payout policy. Capital Holding introduced a living payout benefit in the spring of 1988. It was like the one you saw in the first example, where it covered its own base policy. We were very successful with it, so in the summer of 1988, in a few test agencies, we piloted a new version of living payout. It was like the one you saw in the second example, where it covered other policies. The test results were very successful. As a matter of fact, we found that the test agencies had about a 25% increase in sales over comparable previous periods. That was somewhat surprising because the premium for living payout isn't really very big and it was hard to tell how we could have had a 25% increase in sales from that. We talked to some of the agents who have been very successful with it, and we found out that they were using living payout as a door opener. They could get into a new home

because they had living payout available and that gave them something interesting to talk about. But once they were in, they might sell living payout, or universal life, term, or something else. We found that of all the incremental sales we got because of living payout, only about 20% were living payout itself, and the remaining 80% were incremental sales of other business. We started rolling out the product to the rest of our field force in the fall of last year.

Because our field force is limited to certain markets in certain parts of the country, we recently tried to start selling through what we call "marketing partnerships." We seek out other insurance companies that want to sell our product on their paper and with their field force, and we share the business with them on a coinsurance basis. The advantage to the marketing partner of this arrangement is that they can get into the market much more quickly than they could otherwise and with a lot less effort. We've got a package put together that includes the product that has already been developed, administrative and claims procedures, and filing packages. We also have a tax opinion from an outside accounting firm. The advantage to us of the arrangement is that we can leverage the work that we've already put into this. We can also get a wider distribution of our product.

Typically the marketing partner would do two things with the living payout policy. The first thing they could do is go back to their in-force policyholders. They could have a campaign to provide them with living payout coverage, generate additional premium from the campaign, and make their in-force policies more valuable. Probably the nicest thing about this is that there is really no risk of replacement or cannibalization of your own business. This is one type of product that won't do that. Marketing partners can also use it as a door opener to get into new homes, just as we did.

In summary, I would say that the living payout benefit and the living payout policy have been very good products for us. I think the main advantage of them is that they are so unusual that they give our agents something to talk about and something to distinguish themselves from other companies with.

MR. GOOTZEIT: It is a very interesting thing that Capital Holding has done. Mike Smith will talk about The Provident Life & Accident catastrophic illness rider.

MR. MICHAEL L. SMITH: We're going to talk about three types of accelerated benefits -- long-term care, terminal illness, and what is sometimes referred to as dread disease coverage. I am in wholehearted agreement with Abe that dread disease coverage is about the worst name you could attach to such protection. My preference is living benefits because that's exactly what we're providing: living benefits to meet the needs of reduced or even removed income; benefits to meet the needs of an interrupted life style, such as major modifications to your home; benefits to meet the needs of catastrophic and major medical and nursing care expenses; living benefits to meet financial stress in time of crisis; and living benefits simply to make life more comfortable.

Let's go on to see how we can provide some of these living benefits. There seems to be a common thread in the basic design of all three of the accelerated benefits coverage. The benefit form is either monthly or a single payout. The benefit is usually based on the policy size and, as I see it, for good reason, since one of the primary objectives in developing this coverage is to sell more life insurance. Accelerated benefits are characterized by an advance of the life insurance proceeds. I think that's extremely important, and I'll attempt to expand upon that point more when dealing with some of the filing considerations later. All are contingent upon health insurance eligibility and, as Abe characterized, there are always other requirements.

Let's take a look at the historical background before getting into some of the detail. Dread disease coverage, or living benefits as I refer to them, is attributed to initial development in South Africa. Supposedly, a company by the name of Crusader Life in 1983 offered a rider benefit termed "critical conditions coverage." Basically, it covered eight major health impairments. As I understand it, the idea originated with a very influential agency in South Africa. After development, the agency felt a compulsion to deliver and did so quite well and it is now estimated that these living benefit coverages are attached to at least 70% of the sales in South Africa. From South Africa, the coverage spread to the U.K. I believe it was more attributable to a wandering actuary than anything else, but Lloyd's Life introduced a term life insurance policy referred to as "living assurance." It accelerated 25% of the basic coverage up to a maximum of 10,000 pounds. It was a flop, however, from a sales standpoint. Supposedly less than 100 policies were sold. Misery

loves company, so Cannon Lincoln jumped on the bandwagon, developed a rider which was attached to a permanent life insurance policy this time and referred to it as "critical illness cover." It accelerated 50% of the basic coverage up to a maximum of 20,000 pounds. Cannon was somewhat more successful. It sold less than 1,000 policies. Well to continue the story, Abbey Life picked up the banner and in 1987, introduced a product called "the package plan." It accelerated up to 100% of the basic coverage to a maximum of 100,000 pounds. It was originally introduced on unit linked plans but now is commonly sold with term insurance policies. Abbey was very successful. After a period of 12-18 months, 10% of their sales included this coverage. Abbey Life's introduction of the product was marked by heavy advertising and some in-depth sales training which I believe are critical keys to the sales success of the coverage.

In the U.S., Jackson National introduced a policy in February 1988. It was an interest-sensitive fixed premium whole life (excess interest whole life) product covering five conditions: heart attack, cancer, stroke, cardiac surgery and renal failure. It provided for 25% of the face amount to be accelerated. Well, not to be outdone, my marketing officers asked the inevitable, why can't we do the same? Well, I didn't know why we couldn't. So we immediately launched our project. We called our policy "accelerated benefit life" and introduced it in July 1988. For a number of reasons we elected an indeterminate premium product covering four conditions: cancer, heart attack, stroke and cardiac surgery. To be a little different though, we accelerate 30% of the face amount and waive premiums for the following 24 months. We elected a living benefits coverage in place of long-term-care for a number of reasons. Long-term care is a product for the advanced age market, at least 65 years of age or older. We did not wish to emerge ourselves in the problems of health insurance regulations and wanted to benefit from riding the wave of innovation associated with such coverage. As a result, we felt that living benefits was the best vehicle for us.

A fixed premium indeterminate premium product was one in hindsight that, I believe, was not a good choice but was motivated primarily by systems and administration concerns at the time. On a worldwide perspective, perhaps some members of the audience will be able to shed some further comments as to how things are going outside the U.S. I understand the momentum is building and in virtually any major geographic market area, living benefits coverage is growing in popularity.

Well, let's get on with some of the product features. We'll now talk about the form of the particular benefit, base policies that may be utilized with this coverage, the issue age range at which we feel comfortable in providing the coverage, the types of benefits that are provided, adjustment methods, exclusion and waiting periods, and then the conditions which are covered.

First of all, as for the form of the benefit, acceleration is the name of the game. It can be done either by rider or contained in the base policy as is the case in our product. I'm not familiar with any company currently utilizing or providing this coverage by separate rider. Other companies probably are -- I'm just not familiar with them. It is also possible to do this by stand-alone benefit.

The types of life policies include all major forms. There is certainly no problem with universal life. Excess interest whole life is the base policy form which was utilized by Jackson National. A traditional life form is the policy type we chose, and certainly term insurance can provide the coverage, although I'm not familiar with any carrier currently doing so.

Issue ages covered are within our normal age range. We do not see this as exclusively for the older age market. We provide our product down to age 20; we issue to a maximum age of 70. Some carriers may provide the coverage through age 80. The accelerated benefit expiry age usually has no maximum. That is also the case for our own product. It is in effect for lifetime.

The benefit is usually a single payment -- a lump sum. We pay once and only once. Our particular product provides a benefit of 30% of basic coverage. The range which I have seen under various products goes from 10% up to 30%. The overall maximum benefit is generally in the neighborhood of $75,000-$300,000. Employing a maximum benefit is one way to guard against antiselection. What happens when we pay the accelerated benefit? In our particular form of coverage, all of the policy parameters are decreased proportionally. When we make a 30% payment, we are also reducing death benefit, cash value, premiums by the same 30%. With a universal life or an excess interest whole life type product with surrender charges which are a function of the percentage of the cash value, then your surrender charges would be reduced correspondingly. Cost of Insurance

(COI) deductions on an excess interest whole life or universal life product would, of course, be working against the reduced amount of coverage.

Another measure to minimize antiselection requires us to exclude any payment upon the occurrence of a covered condition which occurs within a 90-day period following issue of the policy. We have found in our filing experience that this has been objectionable with several state insurance departments, but we have stuck to our guns and have not made any changes. Another thing to be concerned with is referred to as the waiting period. This is supporting to claims administration. I understand that the average reporting time on an accelerated benefit is in the neighborhood of 40-45 days in contrast to 15-16 for a normal life claim. A minimal waiting period eases claims administration practices since the occurrence of death shortly following the occurrence of the covered condition can lead to a number of problems.

Health hazards which are covered, typically, are the big four -- cancer, heart attack, stroke, and cardiac surgery. Renal failure may also be covered. I suspect with the second generation of products, we will be seeing additional covered conditions such as organ transplants. In other countries, we will see the covered conditions being extended to include paraplegia, Alzheimer's, and blindness. I expect AIDS will eventually appear on this list, although I think we're all familiar with the uncertainty in connection with attempting to provide AIDS coverage. There is a great deal of information available in regard to incidence rates for these covered conditions. You can find such information in population data, medical journals, government studies, association studies and experience data from other countries, primarily South Africa and the U.K. As far as available detailed sources, data can be found for specific conditions. For heart attacks, the DuPont employees study and the Minneapolis/St. Paul study are particularly useful. For cancer data, the 1978-1981 study provided by the National Cancer Institute is available, and the 1987 Annual Cancer Statistical Review provides some excellent information. Other sources include, for bypass operations, the 1985 Hospital Discharge Study; for strokes, the Rochester Minnesota Study; and for renal failure, the primary source of information is available out of the U.K. However, such studies are primarily population data which we must translate for pricing purposes by making appropriate adjustments. The data for incidence rates are readily available. There is not, however, a great deal of data on survival period. In developing your own data, you will need to exercise a good bit of individual judgment. The major adjustment to be made, of course, is recognizing that you are dealing with general population statistics. You will want to take into account smoking habits. The particular product that our company offered is in the form of non-tobacco as well as tobacco user risk classes. We felt very concerned about the tobacco user products and the interrelationship of smoking habits with certain covered conditions. We have not made the product available to substandard risk classes.

Now let's take a look at policy forms and how to write this type of coverage in a form understandable to the consumer. First, list and define your covered conditions. Be very clear and specific with the language. Be sure the consumer understands what he is purchasing. Our approach was to include our medical director and staff in the process of defining the particular covered conditions. We utilized medical terminology for the specific medical terms and merged that with our own thoughts and our marketing people to see if we could arrive at the most understandable language. We also require an outline of coverage form to be signed by the policyowner upon delivery of the policy. This outline of coverage form restates the covered condition definitions and urges the policyowner to read the policy carefully.

Proof requirements are important to claim administration. Such requirements need to clearly state the evidence of the diagnosis to be submitted, both clinical and pathological, the necessity of any second opinions, and need to prescribe a minimal survival period. Again, it's my understanding that the average reporting time under these types of benefit claims is quite a bit longer than normally seen under life claims. We developed a totally new proof of claim form since we were requiring a second opinion and certification. A minimal hospitalization period with some of the covered conditions is also required. Our benefit is paid once and only once regardless of the number of occurrences of any one covered condition or regardless of the number of covered conditions which may occur. Once the benefit is paid, the policy should be clear as to how the policy is impacted. If the benefit includes waiving the premium, you'll want to be clear as to the period of time for which that is done. Termination of the benefit occurs upon payment of the accelerated benefit and upon operation of a nonforfeiture option, if so desirable.

Now, let's take a look at some of the filing considerations. Those of you who are familiar with filing procedures and experiences will find your experience no different than with other innovative efforts. The inconsistencies between departments and the inconsistencies within the departments emerged from our experience. The approaches of the various states to each of the three types of accelerated benefit coverage -- long-term care, terminal illness and the dread disease are also very inconsistent. We found states very receptive to long-term-care coverage and the same departments very opposed to the dread disease coverage. The primary problems that we encountered were the feelings of the departments as to the prohibitions which they felt existed in their regulations and statutes as to the combinations of life and health insurance. One state felt these types of coverage posed specific problems for its valuation and nonforfeiture laws and another state was very concerned with the uncertain tax aspects.

We were not successful in the states of Pennsylvania, New Jersey, Connecticut, Massachusetts and Illinois. Since getting your home state approval is very critical, those large U.S. companies domiciled in those particular states face very serious filing problems. Additional specific requirements we encountered included incorporating a majority of the standard accident and health provisions and demonstrating compliance that the cost did not exceed 10% of the base policy premium. Things are changing rapidly in this area. We were able to obtain approval in 35 states after very close to a year of intense effort. We feel we will be able to move forward in at least three other states. But, beyond that I feel that it will take specific legislation plus changes in regulations and guidelines in order to move forward. Much to their credit, a number of states are beginning to press forward with enabling guidelines.

As to tax aspects, there's not a great deal that I feel very comfortable in relating to you. We basically feel that the inclusion or attachment of living benefits coverage will not endanger the life insurance treatment of the basic policy. We also feel that the guideline premiums, if your base policy is a universal life type, may not be increased, however, when this type of coverage is attached. This is not a qualified benefit as defined under the code.

As to the accelerated benefit payment, we feel you can consider the payment in two components. One which we would refer to as the health benefit component, which would be the net amount at risk portion, may be viewed as being excluded from taxable income under Section 104. The implications with the cash value component or the cash value associated with the percentage payout, in our case 30%, are dependent upon when the benefit is paid. However, we feel under the restrictions and guidelines within the Code for the construction of the particular product we offer, this particular component should also be excluded from taxable income.

There are marketing aspects -- objectives, measures and results. Why did we go into this? Our motivation was obviously to sell more life insurance and increase the flow of premium dollars. The benefits that are being provided are visible and very desirable. We're convinced that living benefits are here to stay.

MR. GOOTZEIT: We're having a shift from those who do, to those who talk so it's my turn next. I'm in the St. Louis office of Tillinghast. Prior to joining Tillinghast, I was with American General in Houston and decided to make a move. It is easy to find St. Louis -- it's the city on the Mississippi with an arch and no football team. There are two sports in the city of St. Louis. We're into the summer season which is baseball, and in the winter time we wait for baseball. We are hoping that we do have baseball this summer. Last summer some people said maybe we didn't have any spectator sports at all. We were waiting for baseball all year.

I'll be talking about long-term-care riders. I think that in the experiences that I have had with the long-term-care rider, a certain theme has rung through and I'll try to identify that theme as I go through my remarks. The first company that had a long-term-care rider is a mutual company in Des Moines called National Travelers Life. A date which lives with me forever is May 15, 1987. The people there had the idea to go ahead and accelerate a portion of the life insurance policy death proceeds when an individual went into a long-term-care facility and they asked us, Tillinghast, what we thought about that. We had a little presentation with them on the stage. It wasn't quite as formal as this, but I will assure you that some of the comments we made in that presentation found their way to these. They filed in Iowa in September 1987. The commissioner in the state of Iowa thinks it's one of the most wonderful things he's ever seen in his entire life. He gave it approval in just a few days, and National Travelers launched its product and introduced it in November 1987. The second product on the street was independently developed by First Penn

Pacific. (Some of you may have heard Rich Klein describe some of his experiences that were independent of and slightly after National Travelers.) The next product on the street was ITT Life in Minneapolis. A lot of things have happened to ITT Life which made it necessary to redo many of its marketing activities and the long-term-care rider helped feature prominently in that company's restructuring.

We have a marketplace dilemma out there. We have a product for service we are trying to distribute through a channel to reach the eventual marketplace. The question is how does the development and implementation of a long-term-care rider assist in the articulated goals and objectives of the organization? If you go through the companies who have developed and implemented these products, you find a very large range of results when actual results are compared to expected results. I think that actual is the most consistent. I think it is the expected results which vary quite a bit amongst the organizations. So the question is how does the living benefit rider assist? Obviously we get a better product for service. Distribution channels in a number of instances are ready to distribute this product. They feel that the consumer will be receptive to listening to this kind of sales promotion, and the marketplace, I believe, will eventually find its way towards buying a lot of these.

The long-term-care rider -- what is the activity to date? We have identified 19 products which are on the street. There are several more that are ready for release at any moment now. What are the possibilities in the future? We think there will be 60-75 companies with long-term-care riders over the next three months. So, why does the long-term-care rider market well? We think there are real benefits at an affordable price. Well, what are some of these real benefits? Besides getting access to your money early, you have the opportunity to possibly enjoy a death benefit that might have been extinguished because of partial withdrawals or policy loans to meet an unanticipated expense. Imagine a person who doesn't really have very much in the way of liquid assets. The person goes into a long-term-care facility, and he finds out that he has $10,000 of cash value in his insurance policy. Well he may borrow $2,000 in one month to pay for the cost of the facility, and then in the second month he borrows another $2,000. Before you know it, he has a maximum policy loan. That person is not making premium payments, and his policy and coverage lapse.

That's not an anticipated planned event, but if the policyholder has a long-term-care rider, that type of forfeiture of coverage at exactly the time when he needs it would not have to occur. We think there are a lot of benefits to this rider other than just getting the benefits early when you need them.

The other two speakers have already mentioned differentiation, and I think that the topic of innovation and the benefit of innovation has been available previously. That benefit will start to wane as more and more companies enter the marketplace.

How do you know you've been successful? How does ITT or some of the other companies know they've been successful? Here are some of the measures of success. One we concentrate on is how many riders we have sold which is certainly easy to measure. The second point we say we would like to get is additional life insurance. That's harder to measure. Agent recruiting has been a very important goal for one or two of the companies that have the long-term-care rider, and they feel that their recruiting efforts have been enhanced by the prominence they have in the marketplace. The operational results of an organization are the sum of many different items. Some are positive and some are negative. How can the implementation of this particular rider help strengthen the positives and remove the negatives or turn them into positives?

Well, maybe you can identify some of those; as an example -- persistency. I've heard Bill Sweeney of ITT Life says that when he gets done with his life insurance sales, they are replacement proof. He takes a $75,000 life insurance policy, puts on a spouse rider, puts on a disability income rider, which is permitted in some states, and he also puts on a long-term-care rider. He now has a package of benefits which no other company in the United States has. If another agent comes in and shows a universal life policy which has better values than what you have right now, that is an incomplete comparison which should be very easy to deflect. So we no longer have an apples-to-apples kind of situation. If Bill Sweeney and ITT Life can get that policy on the books, he feels that it will never be replaced. So that can help if one of those results is improved persistency.

Marketability -- how many of these animals are being sold? That was that first measure of success. This is an easy one to measure and we get a wide range -- the lower limit of that range is

close to zero and the upper limit of that range is 40%. I would say that the median is about 20%. Twenty percent of those life insurance policies which are eligible to have the long-term-care rider included are in fact having them included. I think that's an admirable goal. I don't have any problem with that being an acceptable result. I think the key differentiating factor between those companies that enjoy relatively more success and those companies that don't is agent-training. Long-term-care insurance is a very complicated thing. You have definitions and all sorts of different things: What happens when you pay out the benefit? What happens to the remaining life insurance and on and on and on? If you take a brochure with all the information and mail it to your agents and that's the last communication you have with them about the way they are going to sell this package, don't be surprised if you find out later that your results are close to zero. It requires a large amount of agent training. For those agents who feel comfortable with this process and make it an integral part of their sales pitch when they go and see their customers, they may actually see a higher closing rate. Stories that we've heard from many of the companies are very similar -- Agent X in this company used to have a closing rate of 4 out of 10 -- he learned the long-term-care rider, made it a routine portion of his sales promotional efforts and his closing ratio went to 7 out of 10. Now is that an item we want to sell or is it more life insurance? It's nice to sell either, but what we really want to do is sell lots of life.

I would like to take a quick tour through product features. Here's the menu of the product features. The funny thing is that this menu is applicable in May 1987 and is just as applicable today or at least 19 products later. We haven't really seen a lot of innovative new ideas on long-term-care riders since we've had the first one out. I'll talk a little bit about some of the provisions up here, and we'll go into some additional detail in a few seconds on the more complicated ones. The form of the benefit is typically a rider on a life insurance policy, but it could be an integrated provision built into the life policy itself. We believe the rider as the form of the benefit also offers more flexibility. The base policy can be any cash value life insurance policy -- any. It does not have to be universal life. It can be universal life, fixed premium excess interest whole life, traditional par whole life -- we've developed products in each one of those. The issue age range is kind of another assist in helping you articulate exactly what your strategy might be. We believe this is an opportunity to increase the average age of your life insurance sales to something in the 40s and 50s. We believe this will sell very well in the 40s and 50s to the extent you have agency field force who can reach that age of prospect. We believe it will sell very well. It could be consistent with other programs that you are taking to reach the golden ages -- Medicare Supplement and other investment products possibly with that age range.

Let's go through these other provisions in more detail. The monthly benefit is always a percentage of the death benefit. There is no individual selection allowed that helps control the financial risk profile of the product. The 2% of the death benefit seems to be the single number that just about every company has adopted with maybe three or four exceptions. There have been some efforts to remove the possibility of overinsurance in large-sized policies, so you might have a step-rated definition or you might cap the benefit at the cost of the facility itself. The maximum benefit is also a percentage of the death benefit -- again, no individual selection. Companies have chosen percentages which range from 48% to 100%. Typically, around 50% or half of a death benefit may be made available for acceleration. The consideration involved is not regulatory; it's a more original purpose -- it's more philosophical. Do you want to make all the death benefit available for expiry prior to death and leave nothing for the beneficiary? So it's a philosophical decision -- not a regulatory decision. One company has solved the problem by offering two versions -- a 50% version and a 100% version and the people there essentially say to the agent and consumer, "You decide, we wash our hands and we'll make both available to you. We don't have a maximum benefit period in these contracts -- 2% is payable per month until you reach 50% or 100%, and those two numbers together will define what the maximum benefit period is. Two percent a month for 25 months gives you 50%, etc."

The kernel or the nut of the matter is how you would actually administer the long-term-care rider and the adjustment method -- what happens to the policy during the period when you're making the benefit payments? One approach has been to attach a permanent lien to the policy. The permanent lien is just the sum of the benefits paid, permanently attached, kind of like a shoe box on the side. Later on when death occurs or when cash surrender is requested, any proceeds which would be otherwise available will be reduced to the extent of this permanent lien. The lapse processing though would continue to occur on the gross amount of the cash value. We believe that's a simple approach. A second approach is to shear off parts of the policy and that's point two -- the partial surrender approach. You would shear off 2% of the policy each month in which

a benefit payment was made. So all of the parameters of the policy are reduced on this proportional basis. Then, of course, there is the hybrid of points one and two -- you have the full amount of the lien against the death benefit and a proportional amount of the lien to cash value. There is one other design but I think we've probably gone through this enough. There are some considerations though if you are seriously considering doing this, the permanent lien approach has now become slightly lessened. We now have a disapproval in one state that does not like the full permanent lien against the cash value. So as we get more responses, a lot of product specifications will probably start a more narrow range.

An underwriting policy provision in this thing is the minimum years in force, and we have a wide range of possibilities here. You can have a provision in just about all states that says that we will not allow any long-term-care benefits to be paid until the policy and rider are in force for a certain period of time. That period of time is up to the company to decide, and we now have seen some variations according to whether the confinement is due to sickness or accident. You might have zero minimum years in force for confinements due to accident, and three years if it's due to sickness. This is the second provision though that may get you disapproved in, I believe, three or four states. Some of the states will not allow this provision, and some will not allow this provision to specify more than one year.

Here are some other gatekeepers when we do a real fancy presentation (I have a little hour glass there which says here's the thing that's going to make you wait before we pay benefits). Every one of these has an elimination period or continuous confinement. You must be continuously confined in a facility for a certain period of time before benefits will be payable. The most popular number is 90 days, but there are elimination periods both longer and shorter than that. The longest period we've seen is six months, and you can install a six-month preexisting condition clause if that will provide an additional benefit -- let's say the spread at risk category. Now are we going to cover all confinements in long-term-care facilities? We intend not to, but we will probably end up covering all of them; but we have this boiler plate language in there that's trying to insure that this person is, in fact, sick. This really rings of metal -- but this is in each of the riders so far. The boiler plate says the confinement must be medically necessary, based on physical limits which prohibit daily living in a noninstitutional environment. Some of the states don't like "medically necessary" -- in those states you can substitute "the activities of daily living" test. "Activities of daily living" is a trend which will become more and more common throughout the states. It is typical among virtually all the contracts to waive the premiums or cost deductions or some other type of benefit to insure that the policy does not lapse while you're making these payments. If you're making a few thousand dollars a month in payments because a person is confined in a nursing home, it's possible that paying the insurance premium may not be defined in your agenda. If you don't have the premium waiver in force, then you might find yourself in the uncomfortable position of having to lapse the policy. The good news is in this envelope, here's $2,000. The bad news is, by the way, you didn't pay your premiums and we're going to lapse your policy. That might be kind of an embarrassing letter to write, and most companies would probably prefer not to.

The facilities covered range from the highest level of care down to the lowest level of care. Skilled nursing, intermediate nursing and custodial facilities, I believe, are universally covered. So essentially, in any of these facilities, you will pay the benefit. Home custodial care is covered in about half of them we've seen on a limited basis. States do not like limited basis and some have just removed it from the contract itself. You do not need to have home facility care in any state in order to get either the rider or the long-term care stand-alone policy approved.

I want to get to compliance and tax. Let's see what our buddies in Washington are talking about these days. I used to say an attachment of a living benefit rider to a life insurance policy will not jeopardize the 7702 treatment of the life policy. I don't think we can state that strongly anymore, but there is certainly nobody around including governmental and treasury officials that would like to disqualify the favorable 101a tax treatment of a life policy because of the long-term-care rider. Unfortunately, you can't weave your way towards that interpretation in existing statutues and regulations. What is clear, however, is that guideline premiums may not be increased. This is not a qualified additional benefit. The ACLI is going through its normal 7702 task force process which I believe has been going on for six years now and has no possibility of ever ending. The task force has recommended to the ACLI exactly what improvements it would like to see to specifically qualify long-term care riders. The ACLI has petitioned Treasury to go ahead and interpret that as the official interpretation (the Blue Book interpretation). The bottom line is

Treasury will probably not punch the topic. Congress has made it clear that it is not going to be discussing long-term-care in this Congressional session. The sense of Congress is that it would prefer not to increase the governmental utilization or the governmental cost of long-term-care and it would prefer to promote long-term-care in private industry. However, that will probably not be resolved this year.

What happens to these benefits when they are received? It would be nice to think that they will get the same favorable tax treatment as long-term-care insurance policies. Because after all long-term-care insurance must be health insurance, right? It sounds a lot like health insurance. Long-term-care insurance is not specifically qualified as health insurance. It is not health insurance. Stand-alone policies do not have guidance about whether or not they get favorable tax treatment on the receipt of those benefits. We believe that's an oversight that will be rectified soon, and the same type of provisions which go into long-term-care policies will extend to long-term-care riders. Hence, the beneficiaries will receive favorable treatment, too. That is hypothetical at the moment. The last time there were legal opinions and tax opinions; I think we all had them. My opinion of the opinions is that they are opinions. My opinion of some of the opinions is that they are good opinions. But I think you might tell from my comments here that it's obviously extremely unreliable to go with opinions as a base for your activities. I think the issue is unresolved, and it may not become fully resolved for another couple of years. It's something we'll have to live with, and I would like to think that the industry will go ahead and promote these benefits anyway. What's happened in these last several months is that my personal activity has now picked up with the larger companies. I'm noticing that the giants in the industry now are starting to get on the long-term-care rider bandwagon. I think to the extent that this becomes a more common benefit, especially promoted by the giants, it will be much more difficult for Treasury to come and retroactively take this away from us when we have essentially deserved it. I encourage you guys to do all sorts of living benefit riders.