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ACCELERATED DEATH BENEFIT PLANS

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Recorder: FRANCIS DE REGNAUCOURT

- Long-term care and "living benefit" riders
- Early sales results
- Benefit structure
- Development of claim costs
- Regulatory and tax considerations

MR. FRANCIS DE REGNAUCOURT: I work for the life brokerage arm of Metropolitan Life. I guess I was called upon to moderate this panel because my company has an accelerated death benefit rider, but I decided to leave the speaking to people who know much more about the topic than I do.

Ben Mitchell, a consulting actuary with Tillinghast in Atlanta, has considerable experience consulting to insurance companies on all facets of product development, part of which has been long-term care riders and dread disease riders. (Incidentally, we will be breaking down our discussion along the lines of these two plans.)

Then we have Tom Hruska, who comes from Jackson National in Lansing, Michigan. Jackson National is part of the Prudential Corporation which, on a world-wide scale, is right up there in a class with Metropolitan, Prudential Insurance and some other biggies.

When Prudential Corporation closed up their operations in South Africa, they felt the place to go was Lansing, Michigan, and they brought with them a great deal of South African expertise. One of the particular pieces of experience they brought with them was in the area of living benefit riders. Jackson National was one of the first companies to get it off the ground. Tom will share some of their knowledge and experience in these kinds of riders.

We were going to have Gerry Goldsholle, Chief Executive Officer of MetLife Brokerage, but Gerry, due to personal circumstances, was unable to come. Instead, we have Bob Goldstone, Medical Director of Metlife Brokerage.

Bob has had a great deal of personal involvement with the design of Living Benefits riders, including the specific medical features. Prior to coming to Metropolitan, he had similar experience designing Transamerica Occidental's rider. He brings with him the knowledge and experience that not many actuaries get to hear.

MR. THOMAS J. HRUSKA: This is the first time I've spoken to a distinguished, or even undistinguished, group of actuaries. Bob was saying that if he were speaking to physicians, he would be extremely nervous, but he is clearly relaxed. Unfortunately, I am not in his position.

I was struck by the emphasis on change. Over the last year or so, we have been hearing a lot about change in the actuarial profession. Change seems to be endemic in our society. Perhaps the only constant is change.

A couple of years ago I was working at a small company in the Midwest owned by a different large European conglomerate. It was announced that, by the first of March, the company was

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going to disappear. It was going to be consolidated in other cities. A few weeks later, that large European conglomerate sent out a book celebrating their 25th anniversary. They gave one to every person with the company. The title of that book was *Secure in a Changing World.*

Change is not only personal. You have seen tremendous economic changes in the last few years in inflation, in interest rates, in the tremendous competition in both the U.S. and globally, and in changing tax laws. The result of all that has been change in consumer needs.

The life insurance industry has been pretty quick to respond to those. We have seen a whole new array of products: Single Premium Whole Life (SPWL), Universal Life (UL), Single Premium Deferred Annuities (SPDAs), Variable Life, and the list goes on.

There are other kinds of changes going on besides personal change and economic change. Tremendous change is going on in the medical profession and in medical treatment. The most dramatic thing today is perhaps the incredible amount of high technology brought into the medical profession and the high cost that goes with it.

If you have looked at the book that we received called *A Hundred Years of Mortality*, there is a lovely chart that shows the major causes of death in 1905: tuberculosis, pneumonia, diarrhea, things that often resulted in quick death (except for TB). But no matter what kind of disease you died of, it didn't cost you much.

Today the leading causes of death are cancer, heart attack, and stroke. Whether you survive or not, it's going to cost you a bundle.

In addition, the elderly are living longer. They are faced in many cases with expensive care. They lose the capacity to operate independently. What this says is that there is a new kind of consumer need out there. The preservation of an estate may not depend solely on having adequate death benefits any more. In fact, the ability to handle high medical costs or long-term care costs may be the only way to preserve one's estate.

So, we have a changing consumer need out there. The elderly may need the money now rather than at death. As with the economic changes, the industry is responding with long-term care, with terminal illness benefits, and with dread disease coverage. All of these offer the acceleration of life insurance death benefits.

I'm going to focus on the dread disease portion of it. Ben's going to talk about long-term care some, and perhaps a little about terminal illness.

There are a variety of names for dread disease: accelerated death benefits, living benefits, living insurance, lifetime benefits. Somebody has even called it living death, although I don't think there's any product out there called that.

What it does is pay a part of the death benefits when a particular specified event occurs. The typical ones are cancer, stroke, heart attack, coronary bypass surgery, and end-stage renal failure. We'll probably see a number of other benefits that are added as time goes by. A couple of companies have added Alzheimer's disease. There is one that has added an accidental injury provision. It's a new product, something that you'll probably have to compete with over the next few years.

Let me talk a little bit about the background and origin of the product. In 1981, Crusader Insurance in South Africa perceived this gap in cover, this problem in needing money for the high cost of death. In 1983, they launched their first product, which provided for payment of a part of the death benefit upon the occurrence of cancer, stroke, heart attack, or surgery resulting from heart disease.

It had a remarkable impact on the South African market. Within five years, 90% of the companies in South Africa were offering a similar product. One of the reasons, perhaps, is that South Africa has a very high incidence of heart attacks, much higher than the U.S. They are very visible kinds of diseases, so the product had a pretty good attraction.

These companies did not necessarily have an easy time of selling the product or dealing with it. In some cases, they had very poor underwriting, and they took bad losses. There were some lessons learned in the process.

The first lesson was to make certain that the contract language is precise. One company learned the hard and painful way that their contract allowed for the payment of the accelerated benefit twice.

Second, clearly define the diseases that are covered. I am going to talk about Jackson National's contract language, and how we try to make certain that we know what we are going to pay.

Third, exclude less serious diseases. There is too much risk of antiselection.

Fourth, there needs to be some kind of limit on the benefits that are going to be paid, both in terms of the total benefit from all companies, and in terms of the percentage of the base that is going to be accelerated. Typically, it should be around 25-50% of the base, and no more.

In 1985, the product moved to the U.K. The first launch was an abysmal failure. The company tried to sell it through newspaper ads, and it just didn't go anywhere. One of the important things about this product is that is has to be marketed very carefully in order to be effectively sold.

Abbey Life took the idea, developed a careful marketing plan, designed a good product, and called it Living Assurance. It became almost an instant success. It covered cancer, stroke, heart attack, bypass surgery, and end-stage renal failure, familiar dread diseases that you'll hear a couple more times before I'm finished.

One of the most important lessons that came out of the U.K. is that you really can't sell this product as a rider. You can't have an agent go out and say "Well, here's a life insurance product. Oh, by the way, would you be interested in buying a dread disease rider (or a living death rider)?" It needs to be sold as a package.

Let me turn now to Jackson National's experience. We have been selling this product now for almost two years. It had its origin at Jackson National due to a very fortuitous combination of circumstances. The national sales manager, Dave Pasant, who is now our president, was looking for a way to put more life into life insurance. At about that time, our chief actuary came from England (we're owned by Prudential of England, not Prudential of New Jersey) to take up his responsibilities. He brought with him experience from South Africa and from the U.K. So we had the actuarial expertise on the one side, and the marketing interest on the other.

The combination produced what we call Lifeline Ultimate. It is a product which provides for acceleration of 25% of the death benefit upon the occurrence of one of five conditions: life-threatening cancer, heart attack, stroke, coronary bypass surgery, and end-stage renal failure, our familiar set of dread diseases.

We were very careful in the definition of both the condition and the requirements for diagnosis. This helps us to avoid antiselection.

For example, in the case of heart attack, we define it as the death of a portion of the heart muscle resulting from a blockage of one or more coronary arteries. Then we have three distinct requirements for diagnosis that have to be fulfilled. First, there must be a clinical picture of a myocardial infarction. Second, there must be electrocardiographic findings consistent with a myocardial infarction. Third, there must be elevation of cardiac enzyme levels.

We must have done a fairly good job of designing our contract language, because we have seen other contracts which not only have the same language, but even have the same grammatical error.

Our contract provides that no benefit is payable if the condition manifests itself in the first sixty days after issue. This is fairly important, because you would have people who would develop a severe pain in their side and say, "I must be having a heart attack" or find a lump someplace and say, "I must be developing cancer. I think I'll go out and see my friendly Jackson National agent and buy a Lifeline Ultimate policy." If they have to wait two months to go see their physician, they are less likely to do that. Strangely, the fear of death overcomes the greed.

The product is an interest-sensitive whole life product. It guarantees premiums and face, excess interest is credited and risk premiums are deducted -- all the normal kinds of things. It's built around our most popular interest-sensitive product, called Ultimate II. In general, the gross premiums are 10-20% higher than that product. So, we've been able to keep the cost of it in some kind of reasonable relationship with benefits.

In terms of the mechanics of the acceleration, we pay 25% of the base, then we reduce the gross premiums, face amount, and cash values by 25%. The policy then continues on at a reduced level.

In effect, before the acceleration you have an extra premium that will cover the cost of acceleration, and after the acceleration the extra premium covers the extra mortality. Typically, these people are going to be substandard after they have the condition that causes acceleration.

One of our major difficulties with this product has been getting state approvals. It was an unfamiliar product; states didn't quite know what to do with it. Was it a health policy or a life policy? Where did it fit into the laws?

In fact, we had to put together three different versions of the product: a basic policy, which had the acceleration language in it, which we treated as a life policy; a health version with a health product and rider, which worked exactly the same, but with different contract language; and a lien version, which provided for a lien in case of acceleration. We have pretty much reached the stage where we really don't need the health or the lien version.

In some states, we couldn't find any way to get it approved. The states could not find any way to put it into their laws. In those states, we have either had new legislation passed or we have simply not been able to sell it.

After two years, we have been reasonably successful in breaking the ground for the rest of you. We have approval in 37 states, with two more coming very soon.

We are pretty pleased with the sales results on this product. We have about half a billion of face in-force, and 5,000 policies. I understand that is considerably better than one of the majors, which has three policies, and I'm not sure how much face.

We have found that these sales results vary considerably by region, mostly because of the enthusiasm or lack of enthusiasm on the part of our regional sales managers. We have done the best in California, where our regional manager is very enthusiastic about the product.

Basically, the most important thing to know about selling this product is that you've got to sell your agency force. If you don't sell them, they are never going to sell themselves.

I'd like to say a little bit about our claim experience. We have had only eight claims, and we have paid about six of them. We haven't seen a whole lot of antiselection. I think that must mean we are doing all right on our underwriting. The claims reflect the prevalence of the diseases. We've had three cancer claims, two heart attack claims, and one bypass claim.

If you're going to try to produce one of these products, you need to have some data. Unfortunately, you don't have any insured experience; there hasn't been any product out there. You might be able to find some in your health insurance business. We didn't have any health insurance, so that didn't help us.

We used population data information to adjust insured mortality for the extra cost of acceleration. The experience must be country specific. You can't simply take South African or U.K. experience and translate it to the U.S.

The incidence rates vary significantly by country. As I mentioned, South Africa has a very high incidence of heart disease, and the U.S. uses coronary bypass more frequently than other countries. It is very much a function of the level of medical care. Most of the data you will find will come from either the U.S. or the U.K. You can use the U.K. data to some extent by adjusting U.K. incidence rates in the cause of death study. There is a way to transfer that data over.

The quality of data varies considerably. You get the best data on cancer and heart attacks, as there is a lot of experience and a lot more studies have been done. There is something of a definition problem with strokes, because the statistics may not directly apply to the definition that you use in your contract. For renal failure and bypass surgery, statistics are much more limited.

For the U.K., there are some morbidity statistics in the Hospital In-Patient Inquiry 1985. I don't think I'll give you that much detail. Morbidity statistics are helpful for heart attacks and strokes, particularly for incidence rates. In the Hospital In-Patient Inquiry, you can pick up some information on removal of kidneys and coronary bypass. The British are very good on their cancer statistics. Every single case of cancer is registered.

The U.S. has less centralized statistics gathering and a greater variety of sources. There are some very good studies. For heart attacks, the Framingham Study is probably the best one, both for incidence rates and for survival rates. This goes back about thirteen years now.

Those need to be adjusted because of the change in smoking habits. The Framingham Study is a little older, and there has been a change in smoking habits. There was an article in the *American Heart Journal* in April 1988, which has good information for adjusting the Framingham Study.

The National Cancer Institute publishes *The Annual Cancer Statistics Review*, with incidence by neoplasm. They also provide five-year relative survival rates. There are no age-distinct survival rates; their assumption is that survival does not depend on age.

For stroke, pick up information from the Framingham Study. There is also a Rochester, Minnesota Study and some other information from the Department of Health and Human Services.

For renal failure, the National Center for Health Statistics has a 1983 study. There are survival rates from a Mayo Clinic study in 1984.

For coronary bypass, see the May 1987 *American Heart Journal* for information.

In the future, we expect data to get better as medical studies continue. In addition, we will begin to see more data on insured lives.

As I said earlier, there are difficulties with getting state approvals. Because of that, we are glad that the NAIC is working on this issue, but we were somewhat shocked to see that they published a proposed guideline which effectively destroys dread disease cover.

They have put together a guideline on accelerated death benefits, specifically on dread disease and terminal illness; it does not address long-term care. It defines accelerated benefits as benefits payable under a life insurance contract prior to the death of the policyholder in anticipation of imminent death. By imminent death, they mean 18 months or less. The effect would be to eliminate any product like this dread disease product.

Let me briefly summarize the guideline for you. I will also give you some ways to have some input into the development of the guidelines.

Qualifying illness is not triggered by a particular type of condition, but by the expectation of imminent death. It has to be certified by one or more physicians. You have all sorts of possibilities there for the physician to be wrong.

Second, there are disclosure requirements. They require disclosure that this may produce taxable income. There must be separate identifiable premium costs. There must also be disclosure of the impact of the accelerated payment on face amount and cash values, and so on, as well as a monthly statement showing the impact after the benefit is paid.

Third, the guideline would not allow waiting periods after date of issue, and it provides that the reduction in value would be pro-rata, so it would not take all the cash value out of a UL policy first.

Jackson National has put together an alternative guideline. We would be happy to share it with any of you who may be interested. It addresses needs for uniform regulation without killing the product.

Our proposal would allow a dread disease provider to have a specified range of diseases. We believe the terminal illness approach simply trivializes what can be a significant benefit.

We generally agree with the disclosure requirements, except that it seems inappropriate to have a monthly statement required after the benefit is paid when there is only one benefit. It would be very appropriate for a long-term care rider, where there are monthly benefits being paid.

We think a waiting period is important because of the obvious risk of antiselection. We think that two or three months is sufficient to eliminate those risks.

As far as reductions of values go, we would agree with them. However, I would think some people who have long-term care riders might want to look at that guideline, where they have a rider that is taking the cash value first, rather than on a pro-rata basis.

The ACLI is working on this. I would encourage you to contact them if you have an interest.

One thing that is not addressed in the guideline is the whole issue of reserving, mainly because it is a consumer-oriented guideline rather than an actuarial guideline.

I am sure there are a variety of approaches to reserving for this product. We have found a fairly simple approach, which provides adequate reserves, that is to modify 80 CSO to reflect the additional cost over a broad range of ages, an addition of about 25% to the q(x)'s. This seems to produce the results we need.

On the taxation of these benefits, the main thing to know is that nobody knows anything. We have an opinion letter from Peat Marwick which says that the cash value of these will be treated as a partial surrender, though there would be some taxable income there, and the rest of the benefit could be treated as a health benefit.

There are people who disagree with that, but we'll have to see what the IRS says on it. There is legislation in Congress right now which would provide life insurance tax treatment for terminal illness benefits, those that pay within a year or 18 months of death. It would be nice to see that broadened to include dread disease.

This is a product which has a future. It meets a real need in the marketplace, resulting from a change in medical care and in the life expectancy of people who develop these conditions.

DR. ROBERT L. GOLDSTONE: I think that it's both innovative and admirable on Francis' part that he decided to get a nonactuary, much less a physician, to come and speak with you.

I won't require you to laugh at my jokes, and I'll try to keep the jokes to a minimum, because whenever I've spoken to actuaries about redesigning a product or figuring out how we could sell it, I've usually found that speaking to an actuary was no laughing matter.

We are part of a new breed of physicians, the ones who got a little bit tired of malpractice and colds and sprained ankles. We wanted to look at government and at business in a little different way. That's how I originally entered the field when I began working with Transamerica Occidental a few years ago.

The opportunity to work for a brokerage company was certainly an interesting one for me. It allowed me to work not as a medical director in the way that you probably all are used to medical directors working. In other words, not where you would take a medical perspective and say, "What's the risk in this," and the physician just advises and walks away. In order to give the company the best value, I have had to give business input as well.

When you look at this type of product, particularly living benefits riders, you get appalled sometimes at the lack of medical knowledge that's put into these offerings. The idea is that you are paying claims and underwriting, based on the fact that these things are all medical, and you

have a decent understanding because you know what the conditions are, what they cover, etc. But you don't keep a medical text on your desk all the time, to run back to and find out exactly what you're covering, and how many different ways a physician can express it, whether it's for underwriting or for claims.

I want to tell you my experiences with developing these riders for three companies. My wife liked what I did so much that she decided to do the same thing and she became a reinsurance medical director at Cologne Reinsurance. When Cologne was thinking about developing a living benefits product, she came to me and said, "Say, you might be a good person to find out what's going on."

The different questions that were involved in developing the living benefits rider with three different companies make it a little different animal than most. The questions weren't necessarily about the types of things involved, but about the types of conditions that were covered, the types of definitions that eventually evolved from what was going to be covered, the amount of money that a company wanted to pay on an accelerated benefit basis, and also how strictly each company would define what it was going to cover.

To date, Metropolitan and Transamerica haven't been quite as successful in selling these as Jackson National has been, although the product is really new in both companies. Market research, when we did it, as well as the opinions of people within the company, indicated that the product could be a real winner, that it filled a definite need, and that it was best to pay someone benefits while they were living, rather than making them wait until they died before they could collect. As hospital bills piled up, people were getting very worried that their estate would be wiped out, and that they would not get benefits until, at least from their point of view, it was too late.

So, everything indicated that this rider should sell well. It has run into government hurdles, but other than that, there is still a good deal of enthusiasm in the market.

We basically looked at four questions that we wanted to answer as tightly as possible. The first was what diseases to cover. The second was how much to cover. In other words, how much do you pay someone who develops a dread disease?

The concept of dread disease cover is probably as old as life insurance itself. When life insurance first started, some policies were written to pay only for certain diseases. Claims were paid in death rather than in life, and it's taken a long time for the concept to be lifted and for people to consider whether some of these conditions could be covered in life.

The third was how to define claims potential. Assuming that we wanted to pay a fair percentage of the defined claims, but not all, how were we going to define what we would pay, when we would pay it, and what conditions had to be met for us to pay the claim?

Finally, how to underwrite. In other words, who would be eligible for it? Would we take a bunch of people who were really increased risks for a given condition and say, "Well, you are not eligible, because your likelihood of developing one of the dread diseases is much higher than the general population?"

All of these were significant points addressed in developing these riders. We also had the benefit of seeing Jackson National's rider, but not of having their claims experience or anything else. We did review the South African rider experience as well.

Basically, there were two problems which people in the company, corporate executives especially, were very concerned about.

First, there was the legal end of things. If we were to sell this product, and claims started to come in, what potential was there for the company to be held liable?

When somebody dies, it's pretty much an open and shut case. There are ways of defining death; there are ways of coming up with a death certificate, or whatever, so that the outcome usually isn't questioned. The person is usually presumed to be dead before the benefits are paid.

Here, basically, you have a live person who can sue. In the U.S. (certainly in New York) and in many other places, suits for benefits are a very important consideration. They can cause the company an immense amount of bad will, particularly if a person goes to *The New York Times*, or, more commonly, the *Daily News* and *New York Post*, the most-read papers for these kind of things in this city.

There was also the possibility of punitive damages. Companies like ours and others are not limited just to the amount of the claim. You can't just say, "Well, if push comes to shove, we're only going to be liable for the $25,000 face amount of the policy that we issued." The fact of the matter is that, by being perceived to act in bad faith, we could be held liable for a lot more than that.

The other thing is that, in South Africa, the policy is always contestable. In other words, if you have a policy that was issued with a proven, intentional, material misrepresentation, that policy is considered to be null and void. With ours, there is a two-year period, and then anything goes.

Two years is a long time, but it's not such a long time for a claim on a product that you're really not 100% sure how to price. You know this better than I do. You're looking at a life product where you're expecting the person to live 25-30 years or so, and then all of a sudden, you have a rider and you're paying a quarter to a third of the policy two years down the road. That has a significant impact on pricing and profits.

When Jackson National's product came out, Transamerica had already been considering the idea, although Jackson National acted much more quickly on it, to their benefit. It was definitely considered a good product, but we had somewhat different ideas as to what we wanted to cover in it.

Whatever you look at putting into a policy, ultimately the policy has to be saleable. In other words, you have to convince somebody that there's a need for it. It was mentioned before that antiselection can be a problem if you cover a lot of smaller diseases. We could have written a rider that would have covered diseases that you have all heard of, which have terrific market value, diseases that people have telethons about, ones that it seems just about everybody has a relative with some form of, that we could have covered quite easily with limited expected payout. But then, would people want to buy a policy like that?

Certain things like heart attacks, strokes, coronary artery surgery, or life-threatening cancer were givens in a certain population. When Transamerica's policy was developed, they were of the opinion that Alzheimer's disease should definitely be covered. Many of you know that Alzheimer's disease is something that attacks you later in life, but by definition, earlier than the normal process of aging would attack you.

The biggest problem with Alzheimer's disease is that it is a very difficult diagnosis to prove. If someone becomes demented before their time, can you determine whether it's Alzheimer's disease or anything else? You can get an autopsy, but the purpose of the policy was to pay before the autopsy, not to perform an autopsy and then say, "Yes, that's what you had," and then sew that person back together and say, "Okay, now we'll pay." Or, we could do an autopsy and say, "That's not what you had, so we're not paying, but we will give you the death benefit."

Whichever way you look at it, you have to be able to, in effect, insure the consequences. It was thought that with Alzheimer's disease, you had to deteriorate to a certain point. You had reached this point when you were unable to handle a certain amount of functions for yourself. This was the idea that the dread disease rider was supposed to cover.

You don't want to think that, if something does happen to you, and ten years down the road, you are unable to take care of your affairs, you are in a nursing home, unable to bathe yourself or wash, and you're not sure if this is January 1 or October 20, or whether Nixon is still the President, someone will tell your family, "Well, he doesn't exactly have Alzheimer's disease, so we're not paying." The idea is that the generic Alzheimer's disease was probably the end result of a person having gotten to that point.

Another interesting consideration was that with the third company, AIDS was considered to be underwritten. There is an obvious potential for antiselection, but the whole industry has potential

for antiselection whenever anyone is applying for a policy. That's what the blood testing is all about.

With AIDS, however, the other thought was that if someone developed full-blown AIDS, not just the traits or complex that precede the disease, the time before payout would be short enough anyway, so why not pay it out. Many people are afraid of it. Anybody who thinks about going for a blood transfusion for any reason at all has the fear that, no matter how good any screening procedure is, coming down with AIDS is a very real risk. And it, too, had very good market value for the amount of exposure that it would give, or for the amount of time by which it would precede a death benefit.

You have to pick diseases that hit perceived needs. In other words, everybody fears a heart attack, everybody fears cancer. If you cover things that don't hit any perceived need at all, you will be covering things that no one will buy the policy for. So, most of these riders that will succeed Jackson National's, our own, etc., probably have to cover a very similar array of diseases.

Our claims potential was definitely a major factor in determining how we wanted to structure things. For instance, when we were read just now the definition of a heart attack, it was called, "the death of a portion of heart muscle resulting from a blockage of one or more arteries."

You can qualify for a policy, you can buy a policy, and an electrocardiogram may not necessarily be a requisite for getting the policy. If it is, it may be close to normal. How can you prove that someone has had a heart attack? Will they come in and say, "I had terrible chest pains. Look, my electrocardiogram is terribly abnormal. I must have had a heart attack." Can a person come in at any given a time and have a scan done by a cardiologist? That cardiologist might say, "Yes, when we put this dye in, we can definitely see that the left wall of your heart is not moving. That means that you probably had a heart attack, whether you know it or not, that affected this wall."

Sometimes it's simple, and you can say it really did happen. But, for people with diabetes, whose nerves are affected by having had high blood sugar levels for many years, this is one of the leading causes of silent heart attacks. You can have a heart attack and not know it. For every film and every presentation that you've seen that says that a heart attack involves chest pain radiating to the back, nausea, severe pressing, etc., you can have a silent heart attack. If you have a silent heart attack, is that paid? Are people going to go out of their way to try to find silent heart attacks? And if that policy is $10,000, it's a big difference from a policy that is a million.

These conversations got more and more esoteric with coronary artery surgery, which is covered by Cologne's proposed policy, and by Transamerica's and by Metropolitan's policies. You have to ask yourself about someone who had a million dollar policy and is presented with a choice by a cardiologist or a family practitioner who said to them and, "Listen, you have a blockage here. We can either do an angioplasty, which is a procedure where a wire is put in and the heart, vein or artery is sort of expanded in order to try and open it up again, or we could do coronary bypass surgery on you, which, in our hands, is pretty safe and no big problem. Which would you prefer?"

Under normal conditions, most people will say, "No, don't crack my chest open. Do the least invasive procedure. If I need to have a more invasive procedure done, I will." But, there was a definite concern over a subset of people that would have chosen surgery, because you're going to pay out 25% or 30% of the face amount, and the physician said, "Listen, there's a chance you're going to need coronary artery surgery anyway."

This is something that the company may have to put up with, maybe not a year or two down the road, but certainly five or 10 years down the road, although the policies may not have been priced for these kinds of things becoming routine.

What Metropolitan finally decided to do was to tie most of the definitions to different aspects of disability, using, for instance, the New York Heart Association classification of where you are functionally limited. In other words, it's not just if you have a heart attack, but what significant disability this heart attack caused you.

Most of the definitions were played with a little, but the idea was that the policy wasn't going to pay you for just having an event. It wasn't designed for that. It was designed for being able to pay at a time when you really needed the money.

Many of you know that you can have a heart attack and be back to work within two months, if that's what you desire, often with the blessing of a physician. Was this the kind of dread disease that we were trying to cover? We asked ourselves that question and said no. What we eventually did was to modify each of these definitions, so that the conditions had to produce something that definitely limited you in some way.

With a lot of these diseases, we found we would be better off if we built waiting periods into them as well. In other words, you don't want somebody to think that they have chest pains, buy an insurance policy, and then find out that there was trouble.

That, however, is a problem with all life insurance. Say you think you're having chest pains, and you really don't know what they are. You can buy the maximum amount policy which doesn't require disclosure of the information because you haven't seen a physician for it. That way, you can have that policy without really misrepresenting anything. Then, you can go to the physician a little bit later, and find out that yes, that pain was indeed heart disease.

Another instance is strokes. A lot of times, a stroke is not a very tragic event. You can have one where you may not be able to use your arm for an hour or two, and then after that you can use it again. You may have a facial paralysis where you can't move the left side of you face. A week later you get that function back again because another part of your brain has been trained to take over for that. When that happens, was that what the policy was designed to be able to take care of? With strokes, we decided that we might be better to build in a period that this deficit had to persist after you made the claim.

Some of these can end up being a claims nightmare. In other words, you don't ever want someone to say, "Well, I did the things that you asked me to. I got this dread disease. How come I'm not getting paid for it?" We had to be as up front in the language as possible, and explain to people that we were not covering random things that would happen to them. It's not like spinning a lottery wheel and saying, "If you get cancer, you get $200; a heart attack, $300," like Wheel of Fortune with a series of diseases.

Basically, you are trying to have the living benefits rider pay you benefits when you need them most. I think that's the universal language of all the benefits letters that have come out, "When you need them most." That means that, to some degree, disability is inevitable as an end result.

Finally, and briefly, underwriting. You want to screen people as closely as possible, so that you're taking in a relative population that is as close to the insurance-buying population that you're pricing. If you wanted to, you could charge 90% of the face amount of the policy in the first year, and you could make money on the rider with just about any population you wanted. With marketing in mind, we aimed to keep the rider premium as low as possible, to get people to agree that they wanted the dread disease coverage, in addition to what they already have.

You could go two ways with this. You could cover almost everything, but make the price pretty high, or cover nothing and make the price real low for it. Companies have experimented with both approaches.

With underwriting, your company has to decide, before it comes out with the product, how important family history is, history of tobacco or alcohol use, history of medication, type of occupation, etc., because all of these affect things like dismemberment or blindness or whatever. You may not be pricing for occupations, diseases, habits or anything else in your mortality, but you might have to price for it here, because you don't have a mortality rider anymore, you really have a morbidity rider.

There are a lot of other aspects that we can cover, but in the interest of holding this down, I'll stop here.

MR. BEN H. MITCHELL: The two previous panelists have covered primarily the dread disease type of benefit. To round out the session, I will add some information on long-term care benefits

and a few comments on the terminal illness type of benefit. I will describe some of the pricing considerations, some aspects of claim costs development, some of the sources of data that you would use to structure these benefits and some brief comments on regulation and taxes.

Before I get into my presentation, I must express appreciation to my associates at Tillinghast, particularly Jim Merwald and Abe Gootzeit, who have made major contributions to the material that will be included in this presentation.

Now, let's take a look at the long-term care type of benefit.

We could structure a long-term care benefit in any of three ways. We could add it to our life insurance policy as a rider. We could include it as part of the base policy, not separable, or we could have a stand-alone policy. These policies are readily available from many sources and are not a part of the subject of our presentation. For this presentation, we will assume that a rider is used, though the same result can be achieved structurally by including it within the base policy.

What kind of base policy might these riders be attached to or might these benefits be included with? It could be a UL policy; it could be a fixed premium excess interest whole life policy; it could be a traditional life insurance policy; it could be term insurance. It hasn't been used much on term insurance so far, but there's nothing really structural to prevent its use. The cost of the benefit, which is intended to be kept low, will look a lot bigger in relation to a small-term premium than a permanent premium. Therefore the activity so far has been centered primarily on a permanent type policy.

The issue age range can be very broad. A typical policy can start somewhere in the 20-40 range, though some have been offered down to age 0. The maximum issue age is generally in the 65-80 range.

Now, how do we define the benefit? We're attaching it to a life insurance policy and we want to make the benefits a function of the regular benefits paid by that life insurance policy, so it's generally defined as a percentage of the death benefit or the specified amount.

A typical example of the definition would be: 2% of the first $150,000 of the death benefit (or specified amount) and 0.5% of the excess, not to exceed the cost of a long-term care facility. One of the problems in designing these benefits is that you really want to offer a fairly narrow range of benefits. The cost of being confined to a long-term care facility varies, but it is in a fairly narrow range, in relation to the size of life insurance policies written. So, some kind of control is needed.

A really small benefit for long-term care is not really worth anything. So you want to get a fairly large benefit quickly, but then you want to cap it. The effect of the 2% on $150,000 builds a benefit fairly quickly, and then there is a small increase as policy size grows.

It makes sense to limit the benefit to the cost of the facility; some have done it, and some have not.

Keep in mind that we don't intend to provide new benefits by attaching this rider, but rather we intend to prepay some of the existing benefits. The total benefit must be limited. This benefit will be defined in relationship to the death benefit otherwise available under the policy.

Most of the policies have maximum benefits somewhere in the range of 48% (which is not a very nice round number, but it is conveniently divisible by 12) all the way to 100%. I would personally caution against the 100% limit. Those who use it have good reasons for being willing to pay the full benefit of the policy on a long-term care basis. But we need to remember the beneficiary, which was the original reason for purchasing the policy. Some happy medium needs to be used. There is no magic number, but it is probably something less than 100%.

As in the previous example, we might limit the benefit to the actual incurred cost of the long-term care facility. The cost of administering that provision could make it impractical.

What happens to the base policy when long-term care benefits are paid out? Some modification is going to be required. There are several ways that can be accomplished. One approach is to place

a permanent lien against the policy, similar in many ways to a policy loan, though there's no interest on it.

Structurally, it's completely different. The lien is an attachment to the life insurance policy that encumbers both the cash value and the death benefit of the policy, dollar for dollar.

Another option is the partial surrender of the policy. Each time a benefit is paid out, we surrender that portion of the base policy. The mechanics of doing that may be a bit complicated, and there are potential problems with the guideline premiums and all the issues that have evolved concerning partial surrenders, so there may be some disadvantages to this option as well.

Those were the two options that were used in the early policies. A third option is emerging now, and seems to be becoming quite popular. This option is to use a modified lien, where the full lien applies to death benefit, but a proportionate lien is applied against the cash value. This has much the same impact on the benefits as the partial surrenders, but with less complication.

Let us look at a simple example of the impact of these three approaches. Assume a policy that's going to be adjusted by each of the three approaches. It has an $80,000 face amount, a $20,000 cash value, and we will assume a pay-out of $10,000 of long term care benefits. What happens under the three adjustment methods?

Using the lien approach, the death benefit is reduced by $10,000, from $80,000-70,000, and the $20,000 cash value is also reduced by $10,000, from $20,000-10,000.

Using the partial surrender approach, the same reduction occurs in the death benefit, but we have only surrendered 1/8 of the policy, $10,000 of $80,000, so we only take away 1/8 of the cash value. Or, looking at it the other way, the cash value started out as 25% of the face, and after the adjustment it's still 25% of the face, or $17,500.

Under the modified lien approach, the same death benefit and cash values result at the time of the adjustment as using the surrender approach. Over a long period of time, after the benefits have been paid out, the detailed mechanics will produce somewhat different results using the surrender and the modified lien approaches, but they have much the same effect.

Let's look at several internal controls that could be built into a policy design. The period of time that the policy must be in-force before benefits are payable under the rider is a good underwriting control. Something between 0 and 3 years would cover most of the benefits, though one of the first benefits had a 10-year wait.

There is a trend towards shorter waits, as people have gotten more comfortable with the benefits (whether there is a good reason to get a little more comfortable or not). A lot of the benefits have a different waiting period for accident and sickness; maybe none for accident, and one year or some number of months for sickness.

Another item to be considered is a waiting period when the policyholder enters a facility. Most benefits have some waiting period; 30 or 60 days are common, although up to 180 days is found as well.

Another provision that has been used recently, probably because it is specifically included in long-term care regulation, is preexisting conditions. That is, if a claim comes in within six months of issue, it will be excluded if it had been treated within the six months prior to issue.

How do we qualify for benefits? First of all, we must be confined to a long-term care facility. Early policies used the terminology, "confinement must be medically necessary." More recent policies have taken a more disability-oriented approach and have related to activities of daily living. You must be unable to perform two of a list of five activities of daily living.

What would some of these activities be? One list that has been used had five activities: dressing, transferring (being able to get up and move around), preparing their own meals, feeding themselves, and toileting. There could be a number of others that are listed as well. If you cannot do two of those, then you are qualified for benefits under the policy.

Waiver of premium is a major benefit under these coverages. It does not make sense to pay a benefit for long-term care if you also require them to pay a premium. So, most of the benefits offer a waiver benefit while long-term care benefits are being paid.

Extension of waiver beyond the end of the regular benefits, before the maximum is reached, is common. When maximum benefits are paid out, you have a permanent lifetime waiver of premium from then on. Obviously, this waiver coverage has to be coordinated with the regular waiver that might be attached to the base policy.

We have to be careful to define the facilities used to trigger the benefits for confinement. There are generally three levels of facilities that are defined: skilled nursing, intermediate nursing, and custodial care. Then, there's a fourth category, home convalescent care, which is not as clear.

There are well-accepted definitions for the three facilities. The distinction between them is important if you are going to pay different benefits for different facilities. Most recent riders pay full benefits for any one of the three facilities, so the differences aren't all that important.

There are many variations in home convalescent care, and it has special provisions. Generally, prior confinement to one of the three confinement facilities is required before home benefits will be paid. You need a physician's certification that, were it not for the home convalescent care, confinement in a facility would be required.

Generally, there are some internal limits on the home convalescent care, maybe half of the maximum monthly amount, and payable for only twelve months, or some short period of time like that.

That was a brief description of the long-term care type rider. Now, let's compare it to the dread disease rider that has already been discussed. There are some similarities, but there are a lot more differences than similarities between the two types of coverages.

The structure of the benefit for long-term care is a monthly payment, where dread disease is a single payment. The maximum for long-term care is generally much higher than for dread disease. The adjustment method is almost always partial surrender on dread disease, but for long-term care it may be lien or partial surrender, with lien probably being more prevalent. The trigger is a confinement to a long-term care facility for that benefit, as opposed to specific diseases for the dread disease.

Now, a very brief look at the terminal illness type of benefit. There are a few companies writing it, but it could become more popular if the NAIC regulation pushes people in that direction.

The qualification is a life expectancy of less than six or 12 months, with 18 months being used in the regulation. Another definition that's been used is an 80% chance of death in the next year. There could be others as well.

The benefit to be paid out is a percentage of the face amount; 20-50% are the levels that generally have been seen.

Here are some general comments on the pricing of these benefits. You can't price these things by themselves. You can't just say that you're going to price your long-term care benefit or your dread disease benefit, because it has many interactions with the base policy to which it's attached. You have to profit test both the base policy without the rider and the base policy with the rider. The difference is the impact of the rider.

What are some of these interactions that we have to pay attention to? When we pay accelerated benefits early, we are going to reduce the death benefit and the surrender benefit. We may also reduce the premium, if we use the partial surrender approach. We have extra premiums and cost of insurance rates to reflect in our fund calculation, if we have a fund-based product. And, we need to reflect the reserves for the riders as well as for the base policies.

There are two general methods to use: the single population and the dual population.

Let's look briefly at the single population approach to pricing these riders. In this situation, everybody is in one pot; one set of assumptions is applied to the entire insured population. It ignores any differences that might exist between those who have already had a claim and those who have not had a claim. It's a reasonable way to price long-term care, and fairly difficult to use for dread disease.

I have good news and bad news about the single population pricing. The advantages are that it's simple, and it doesn't require making up new assumptions. The disadvantage is that it may not be overly accurate, and the quality of the estimates is unknown, that is, you don't know what your tolerance for error might be.

Now, in a dual population approach, we start with a group of lives at issue, and over time we end up with two groups: those who have had a claim and are impaired, and those who are healthy. Having split the population into two pieces, we either can or must, depending on your point of view, set mortality rates and lapse rates for the two groups separately.

You might set the rates for those who have already had a claim, which would imply higher mortality and probably lower lapses. If you already knew your assumption for the entire group, then the nonclaimants are the difference between the total group and the claimants, getting lower mortality and higher lapses. We also must recognize that the different groups are getting different benefits payments.

This approach also has some pluses and minuses. The advantages are improved accuracy, more detail, and direct recognition of the changes in status and their impact. The disadvantages are much more complexity, and the need to make some assumptions that we have never had to make before, with which we may not feel comfortable.

Special considerations on assumptions may fall into three categories: claims costs, mortality and lapse, and expenses.

Let us first look at mortality and lapse. Again, we can use either the single or dual population approach. If we use the dual population, we have a special assumption to make for the mortality after a claim, and the persistency after a claim. There will be a lot of judgment involved.

On the expense side, all of our different types of expenses will be affected by the existence of the rider. You have to pay commissions on the premium for the rider. There is special underwriting to be done, which affects acquisition costs, and there is some increase in maintenance expenses for the rider. We have to think about claims expenses as well, which we don't usually pay much attention to in a life insurance policy, particularly for the long-term care type of continuing monthly payout.

Now, let's look at the claims costs for dread disease first. I'll go over this rather quickly, since Tom has already addressed a lot of it. There are two general areas. Where are we going to get the data? And, how are we going to adjust it if we need to? I think we do need to because we have population data rather than insured data.

Our claims cost is going to be the probability of a claim times the benefit amount. We know what our benefit amount is, so the probability is all we need to look at. There are many sources that we could use to get the data for our assumptions. It's all population data, because there is no substantial body of insured data. We can go to medical journals, the government, associations, and, with care, other countries. The best known heart study is the Framingham Study. There is also a Du Pont employee heart study. The National Institute of Health has a lot of good information on cancer as well as other diseases. The American Cancer Society is a good source. The Center for Health Statistics also has a lot of good information. There are others; you can be creative in finding your information.

Wherever it comes from, you have to pay attention to its credibility and to how you are going to adjust. You have to adjust from the population to the insured basis. Selection is going to have an impact, maybe positive selection, maybe antiselection; you have to think about the effects of that. Very little of the data is distinct by smoker/nonsmoker status. It could be adjusted if the base policy has smoker and nonsmoker rates.

On interdependence of events, we are only going to pay one claim if we write our policy carefully enough, and we may need to do some filtering out of one claim showing up in a bunch of statistics. Likewise for multiple occurrences; if you live through one heart attack, you can have another one, and we don't want to factor that into the claims costs, because we're not going to pay on the second one.

A lot of judgment is involved, and a lot of uncertainty. Hence you need to monitor the experience that emerges and, if you can structure it, to set your premiums on a basis where you can modify them later on.

Now, let's look at long-term care. The claims costs for long-term care are a function of the frequency or incidence rate, the amount of a benefit annuity (kind of a disabled life annuity), and the benefit level.

Looking at the sources of data, there are fewer sources here. Again, we have population data. The primary source is a 1985 Nursing Home Study published by the Department of Vital Statistics of Health and Human Services. It needs many adjustments to use for this purpose. There has been a little bit of information in the *Transactions*; a publication called *Gerontologist* has had a number of items that are useful.

After we have primary data, in order to develop incidence rates, we have to make a lot of adjustments. Age and sex may have to be factored in more carefully than what is found in the detailed information. Smoking habits, duration, and the effects of selection need to be recognized. Minimum waiting periods after issue, waiting periods after confinement, and preexisting conditions all need to be factored in when coming up with insured population assumptions.

How long will the benefits last once they start? Again, from the same sources, we need to put in a lot of the same variations. Here, you recognize the maximum benefits that you'll need to pay, and the waiting periods that are involved. You want to discount the string of payments to get the present value of the payout annuity, using an interest rate for discounting based on a realistic rate as opposed to a valuation rate.

Home convalescent care has its own special problems. There are very little data; you are really out on a limb trying to figure out what this is going to cost. Keep in mind the prior confinement requirement. Adjustments are going to be very subjective. Again, monitoring experience could be very useful.

You can't forget the impact of the waiver benefit that we are going to provide. The increase to the basic claims cost is going to vary widely by age, and any extended benefits need to be recognized.

As you go through a process to develop the costs, probably the best way to reflect them is as a percentage of the base costs, to keep the pricing from getting completely out of hand.

Now, just a few comments about taxes. There are many more questions than there are answers. I encourage you to get some outside opinion, either in the form of a legal opinion, or an IRS private letter ruling. There's been a little of that attempted, but not too much from the IRS yet.

Questions relate to the definition of life insurance for policyholder and company taxation. Section 7702 defines life insurance for tax purposes. When that was written, these benefits didn't exist. Therefore, not surprisingly, they are not included in the list of qualified additional benefits.

The general feeling is that the attachment of these benefits will not jeopardize the treatment of the base policy, but the treatment of the rider is very unclear. The ACLI is working on improving this situation. There really is no known resistance in the IRS to recognizing these benefits, but a lot of work needs to be done to make it happen and it's not going to happen for probably another year.

What about company tax? The two big questions are reserve deductibility and what tax basis reserves should be. There is an existing private letter ruling that came out early this year, where the policy in question was a group long-term care stand-alone policy. That ruling said that, in

those circumstances, as long as you use a well-defined table (though it may not be as recognized as they generally like) with an interest rate and the normal mechanics, the reserves on the policy would be acceptable as life insurance reserves.

There is no real statement on how to do tax basis reserves. You can use a table that relates to your pricing, and you can probably make a good argument that it's a useful, though maybe not recognized, table. Use regular life insurance interest rates, Commissioner's Reserve Valuation Method (CRVM) reserves, and take your best shot at it.

Policyholder taxation is very important, but it's very undefined. The big question is what kind of benefit do we have? Do we have A&H, life, or something else? It's unclear, and legislation is needed to make it become clear.

Late in 1988, the North Carolina department wrote to the IRS with a hypothetical situation. The policy described was a dread disease type, a single payment for a specified event. They asked if the benefit would be tax deductible.

The IRS reply said, "You can't take this as an official position, because it's a hypothetical situation," but the answer was not good news. They said the accelerated payment was not a death benefit under section 101(a), but they couldn't find anything else that it was, so the payment would be taxable to the extent that it exceeded the basis in the contract. This is not an attractive answer.

A lot of work needs to be done to develop a reasonable taxation for these benefits.

On the state approval front, state approvals have been difficult. At this point, 40 or more states have approved at least one contract of both the dread disease and the long-term care type. Obviously, the details of the design are important in whether a particular state will approve a particular policy.

Most of the problems have involved states not feeling that they have a basis under which they can approve an A&H benefit attached to a life insurance policy. A number of states have withheld approval on that basis. The laws are new and evolving. So, having approved one benefit doesn't necessarily mean that they'll approve another one.

A little bit on sales results. Other companies' results have been mentioned. I checked our records and found that Tillinghast hasn't written any of these policies. I think it has something to do with problems with our insurance license.

I checked with a couple of companies that have been writing long-term care for some time to see what their results have been. Theirs have been better than ours.

Company A has attached this policy to 40% of their UL insurance policies issued in 1989 on an individual basis. They also write payroll deduction, where they don't offer the benefit. Their benefit has a very low cost and very limited payout; they think that has helped this response. They were active in single premium sales, and they found that their sales didn't fall off nearly as much as expected with the tax rulings. The presence of the long-term care benefit helped to keep that business going. They also feel it has helped them attract agents and to retain some important agents.

Company B, on the other hand, attached a rider on 5% of their sales in 1989. They started writing it late in 1988. Current sales have a somewhat higher percentage, but not anywhere near 40%, as far as they can tell. They have had problems with approvals, and they are only approved in about half of their states; they have fairly restrictive provisions on their contracts. That has had some effect.

They feel that the benefit hasn't been sold well to their field force. I would reinforce the comments made earlier that that's probably the most important part of getting it sold. They do feel that it's getting them good publicity, and that it has attracted some agents to them, even though they're not selling it.

MR. ANTHONY WALTER BOSTON: The Abbey Life policy in England was mentioned earlier. I don't know if it was brought out that that policy actually provided for 100% acceleration. In addition, it included a permanent and total disablement benefit, thereby picking up people who contracted other diseases. That said, it's not so much different from the U.S. version with only 25%, because the Abbey agents were told to sell at least three times the base plan as well, so it did come down to 25%.

This product is also spreading very much worldwide. Off the top of my head, I just listed some countries where I know that it's being considered, if not actually being written: Singapore, France, Hong Kong, Trinidad, Greece, and Australia. I cannot emphasize enough that each country has its own separate rates. You cannot really transfer from one country to another without a lot of thought and statistics.

Finally, I can reinforce that what the last speaker said about getting a definition is correct. There is a story, which is true, about a South African company setting this policy up in the very beginning. They got their definition sizably wrong. They had to pay the full face amount on a heart attack in 6 months. After another 12 months, they had to pay out another 100% when the guy had another heart attack, and another 12 months later, they paid another 100% when he died.

MR. STUART L. SORENSEN: I'm aware of some companies that are offering the accelerated death benefit as a rider, a stand-alone rider, optional onto a base policy. What risks do these companies run and how might they minimize them?

MR. MITCHELL: I think most examples of these coverages are riders, rather than built into the base contract language. There is at least an apparent administrative advantage to just creating a new document to attach to other policies, as opposed to developing a new policy form for each base policy you want to attach it to.

I think the biggest risk of doing it as a rider is making it appear too optional to the field force, probably more so than to the mind of the purchaser. If you're going to offer this benefit, you would like it to be attached to all of your policies, or some very high percentage, just excluding those people who have a special risk that you don't want to assume. So, the closer you can come to that, the happier you are about the success of the endeavor. If it's built into a base policy that's popular, it's going to get sold by being there.

If it's a rider, then the agent can choose not to approach it, say not using it when he's in a competitive situation, and including it when he's not competitive, or something like that. If you're going to use a rider, you ought to make the point with the field force that it's a good thing for almost all purchasers to have, and to make it very easy for them to write the policy with it, and, if possible, to make it a little difficult for them to write the policy without it.

What you'd really like is to make it tied as closely as you can and get it written as often as possible.

MR. JOHN M. BRAGG: With regard to the dread disease version, I wonder what any of you would think about simply issuing it as a free-standing policy, presumably a health insurance policy, not attached to a life policy at all? Is this a practical thing? Has it been considered at all, so that it would not impair the life benefit at all that the person had?

MR. MITCHELL: Without being able to name many names, it is my impression that it is being done, that there are a few stand-alone health policies that pay benefits for the same array of diseases. Somebody else could either say I'm entirely wet on that, or provide the detail of who is doing it.

The biggest disadvantage to it is that it's very expensive. Even attaching it to a life policy, where you're not paying out any extra dollars, but just paying them much earlier than you might otherwise do, has gotten some resistance, both from the field and from the purchasers. It's not a trivial benefit; there is a substantial cost to it, and that cost is much greater if it's a stand-alone policy, where you don't have a base premium picking up a large part of the cost.

MR. WILLIAM E. MASTERSON, JR.: It is curious, on both the dread disease product and the terminal illness benefit, that AIDS has not been specifically mentioned as one of the dread

diseases. Does anybody on the panel have any comment on why that wasn't one of the five or six dread diseases?

MR. HRUSKA: I think that we're scared to death of antiselection with it.

DR. GOLDSTONE: I think that it's a good point and that it has been considered. One of the companies that has put out a rider has included AIDS with it. You should be careful to define AIDS as having the full-blown disease, not just an AIDS-related complex, in which case you could have some of the signs of AIDS, but not develop it for years and years, and do all right. Many people who have been infected have gone on for up to 15 years, surprising physicians.

If you really have full-blown AIDS, the time from definition to the time of death is not long, so it doesn't really provide the company with too much window to have to cover a benefit.

MR. MASTERSON: I realize this presentation is on how to make this product work. Tom mentioned that it was important to have a product for which there was a real need, or at least a perceived need by the public.

For both the terminal illness and the dread disease coverage, would it not make more sense, when the individual needs funds prior to his death, to go to a bank and borrow the money and assign his traditional life insurance coverage to pay off his loan in the event of his death? That way, you avoid the federal income tax problems, and the problems of trying to define the specific causes of death, or defining the triggering points here. In other words, let him have life insurance that pays for death for any cause, and use that to pay off a loan which would provide the cash that he would need while he was still alive.

MR. MITCHELL: I think that's a viable possibility. I think a large percentage of the insurance-buying public don't have a good working relationship with a bank, or that would never come to their mind. To the person who does have that kind of facility available, it makes sense. But, I think that this is a way of trying to make it readily available to the masses, and the other approach, while it might work, might be hard to get them to do even if they understood it.

MR. MITCHELL A. SCHEPPS*: Why not come up with a product, whether it's dread disease or long-term care, where the initial life insurance benefit didn't decrease, because if a person is buying insurance, then supposedly he or she needs it. When that person goes into a long-term care facility, or has a heart attack, all of a sudden the death benefit is depleted quite a bit.

MR. MITCHELL: Cost. It's so much cheaper to pull off some of the existing benefits than to create entirely new benefits. In my limited experience, the cost for this type of benefit is large enough to produce buyer resistance, and a fully stand-alone additional benefit would probably be at least twice as expensive.

MR. SCHEPPS: Wouldn't you really be providing more of a need?

MR. MITCHELL: Only if they buy it.

MR. JOEL M. STEINBERG: Can you briefly go through the mechanics of how that lien approach and that surrender approach work when the policyholder has borrowed all his cash value? What would the pay-out be like at that point?

MR. MITCHELL: Whatever adjustment is made to the cash value is made pro-rata to the loan. So, if you had, say, half of the cash value borrowed you would cancel half of the loan. The full lien approach generally goes to the cash value first, before it really gets into the death benefit. That thinking obviously falls apart if the cash value is heavily borrowed, and you go directly against the death benefit.

I think we will see the full lien approach used very little as we go forward, though some will still like it. But in the surrender or in the partial lien approach, you keep the relationship between the net cash value and total cash value the same after the adjustment as it was before the adjustment.

* Mr. Schepps, not a member of the Society, is Marketing Representative of the Cologne Life Reinsurance Company in Stamford, Connecticut.