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LIVING BENEFIT RIDERS

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- Contractual benefits
  - -- Long-term care riders
  - -- Catastrophic illness riders
  - -- Terminal illness riders
  - -- Combination (Prudential)
- Extra contractual benefits
- Annuity benefits
- Marketing results
- Regulatory activity
- Tax status
- Pricing considerations and reserves
- Underwriting and claims

MR. ABRAHAM S. GOOTZEIT: Tim Twiss is an Assistant Vice President of Reinsurance for Lincoln National on the West Coast. He is in charge of program design and pricing. He's been with Lincoln for approximately four years. His involvement with living benefit riders is that Lincoln is actively involved in soliciting reinsurance for these programs. Jim O'Connor is Vice President and Assistant Actuary at the Prudential. He has responsibility for individual product development, tax reporting and disclosure to policyholders. He's been with the Prudential for 13 years. In particular, Jim is responsible for the product design and pricing for Prudential's living needs benefit product. I think it's a clever design and has had a lot of very favorable press with their one press release. I'm with Tillinghast in St. Louis. I've been in St. Louis a little more than three years. I've been involved, on the consulting level, with the development of quite a few living benefit riders for various companies.

I will start with a few introductory comments. Then, Tim will discuss an overview of a number of living benefit riders that feature general product specifications. We'll try and identify those products that the marketplace has been converging to. When Tim is through, Jim will discuss Prudential's product in some detail; the motivation of the product, the product specifications, the regulatory environment as Prudential sees it, and how the product meets the goals of the organization. Then I will conclude with a discussion of a number of additional living benefit riders issues that will include regulatory activity, tax status, pricing issues, and reserves. I will also comment on how you incorporate living benefit riders into your administrative system and what pitfalls to watch out for.

I'm calling this meeting living benefit riders, which is a change from accelerated death benefit riders. I'd like to propose living benefit riders to be the generic descriptive name

for these life and annuity product features that allow the policyholder access to proceeds which are generally available only on death. I like it better than accelerated death benefits, because that title has been used for two separate areas: one is the generic title for all of these products and the other is used for proceeds which are payable when somebody suffers one of five catastrophic illnesses, which makes this title more confusing.

Generally, a company's primary emphasis in entering a living benefit rider program is to sell more life insurance. It's really as simple as that. So, most companies are trying to accentuate their life insurance portfolio and differentiate their products from others and believe that the living benefit rider concept allows them to do that. That's the first reason I think that living benefit riders have been so popular.

I'd like to identify some companies that entered the living benefit rider field early and have advertised in trade journals and so on. Thus, there are not any trade secrets.

By comparing the early companies and the later companies, (Table 1) you can see that we're following a trend as the larger and better known companies are entering the living benefit rider field. And as these companies enter I think the publicity that is going to be generated will be considerably greater. It will be easier for other companies to enter this kind of activity. That's the introductory material to motivate the reason why I think the living benefit rider is an important field and product at the moment.

TABLE 1

Early	Later
National Travelers	Transamerica
First Penn Pacific	Lincoln National
ITT Life	Metropolitan
Jackson National	Aetna
Golden Rule	Prudential
State Life	John Hancock

MR. TIMOTHY F. TWISS: The common thread that I see in the products that we're going to be discussing is the fact that typically a payment from any one of these product features involves a reduction to the life insurance benefit. So it's an either/or situation; not, for instance, a long-term care (LTC) product added in addition to the base life policy. These products involve acceleration of, or payment in lieu of, a base policy death benefit.

I'd like to list some of the reasons for getting into the marketplace. A couple of years ago, all of a sudden, we had somewhat of a slump in universal life sales, and a lot of companies were suffering from a downturn. These riders can increase life insurance sales. There was some additional information available. We were getting new data from overseas and thus thought we could price a catastrophic illness product. The 1985

National Nursing Home Survey was a fairly credible report that became available and started making people think they knew a little bit about the numbers behind these products. In addition to these reasons, the riders themselves should generate a certain amount of sales and profits, especially in the early years when they're innovative and companies can find their niche and have a marketing advantage. These riders are very visible and desirable. There's certainly social good connected with these. For instance, medical costs are rising and these riders offer a way for people to cover that, as well as long-term nursing care. The federal government doesn't appear to be too inclined to take care of long-term care costs, at least not the full benefits. So the private sector is being expected to take care of these costs via such things as these riders. All of these factors led to their manifestation at about the same time.

When you're envisioning these riders, there are basic design elements that have to be kept in mind which are new to someone who's previously worked only with life insurance products. The benefit can be a single benefit or periodic payments. Again, it's related to the policy size and is intimate to the base policy. It's going to impact the base policy benefits should a claim be payable on one of the rider features. In addition to that, other items that have to be built into the rider are a clear description and understanding of the claim costs, as well as any claims control features that you can think of.

Structurally, this benefit can be a rider, policy feature, or some sort of extra contractual agreement. It can be a contractual agreement on a base life insurance policy; or an extra contractual agreement for a life insurance base associated with an annuity contract; or a combination of these. Let's start with benefits that are typically in the form of a contractual relationship with a life insurance policy, including long-term care riders and catastrophic illness riders. A little newer on the scene are terminal illness riders. Some of these have a front-end charge of 3% or so. If a terminal illness is diagnosed, a portion of the benefit can be paid. Even more recently, Prudential has developed a back-end loaded product where there's no charge up front but the benefit is discounted at claim time. Again, you could envision a combination of these features.

Let's look at long-term care riders now and the companies that got into these riders early. National Travelers was the first in late 1987, and Tillinghast was instrumental in developing that product. First Penn Pacific, I believe has two designs, one of which is a rider and the other is their assured care product with the long-term care feature embedded in the contract. ITT and Security Connecticut developed riders in early 1988.

The long-term care benefit is typically a monthly benefit based on some percentage of the death benefit, or specified amount if the base plan is universal life. You have to be very specific on the percentage and whether it is going to change from month to month or be frozen at time of claim. One example would be 2% of the first $150,000 plus .5% of anything over that. You have to really look at your own product, your own marketplace. For example, a $100,000 policy would pay $2,000 a month or 2% of the face amount. On the other hand, a $1,000,000 policy would cap out at about $7,000 a month, paying .7% of the face amount; yet the premiums typically are charged related to per thousand of the death benefit. So average size becomes a very important consideration in pricing.

Another design feature is cost control to restrict the amounts that are being paid. This could be done in several ways. Government program offsets could be introduced that offset the rider benefit amount by the outside payments. You may want to limit payments to actual expenses incurred. If you're also a health, not just a life, shop, you might have administration in place that could track receipts. Alternatively, you could cap the benefit at an arbitrary amount, such as $3,000 a month, that could go higher as medical costs increase. This isn't all negative. In fact, it could be a marketing plus, because typically if you do cap the monthly amount it extends the period that payments can be made. Also in this area, it would be natural to ask about other similar coverage in force. However, we haven't seen too many companies modify their applications.

As far as maximum limits on these riders, some companies specifically are not paying out the entire face amount, capping it at, for instance, 24 or 48 months. Two percent a month for 24 months would be about 48% of the policy. Other companies are willing to pay out the entire death benefit on a periodic basis under the rider. I don't know if states prefer one or the other or if regulators would say this is really not a life product anymore. The result is a payment period of 24-50 months which lines up on the short side of a typical nursing home stay of about 18-24 months. The potential is there for a longer confinement.

Some companies have issue age limits all the way down to age 20 with a cap at about 75. Other companies have a minimum issue age of 40 since they feel this is really an older age market and there's not much sense talking to a younger group about it.

A benefit payment typically reduces the base policy benefit dollar for dollar. If the rider is attached to a cash value product, as is normally the case, the cash value will be reduced. This could happen in a couple different ways. It could be a lien against the cash value where the operation of the monthly fund accumulation does not really change. You're still processing your $100,000 policy in full, but you're tracking an offsetting lien against the death benefit for the full amount, and against the cash value for either the full amount or a proportionate amount. Other companies have built into their system the processing of each monthly payment as a partial surrender. I think the First Penn product specifically recognizes that you can get at the cash value any way you want at any time you want. Their wording makes it look very flexible. The 2% of the net amount at risk piece is separate from the 2% of the cash value piece. They further identify that you can get at the cash value on a flexible basis either more quickly or less quickly than at the 2% payout rate.

Premium waiver is another feature that has to be considered. This is an older age marketplace. Your base policy probably already has a waiver provision in it. The rider premium waivers on the market right now typically waive the base and rider charges during the benefit period. Some go further and continue to waive the base policy charges during the extent of confinement, even if benefits run out. It has to be coordinated with the other disability waiver. It certainly won't be an employment-type provision in a waiver associated with the rider itself. Premium waiver is expensive at these older ages since you're waiving some pretty hefty charges, and therefore some companies have chosen not to offer it. One company that's chosen not to offer waiver provides that during confinement, it will continue to take the charges out of the cash

value until it runs out, then take the charges out of the monthly payment until that's gone.

To eliminate the short-term stays, a 90-day waiting period after nursing home confinement is most common right now. Also associated with this product, getting more towards the health nature of it, is a preexisting condition clause.

On the care level, most companies are now providing benefits where the confinement itself or the medical impairment is of a kind that would require skilled or intermediate care. The facilities allowed must be worded carefully in your rider. Some areas of the country are requiring geographical variations. A custodial care facility could conceivably provide intermediate care or skilled care. Some of the regulators will let you exclude custodial care but not a custodial care facility, even though the intent is to cover a certain level of care. Finally, a hospice is sometimes an allowed facility.

Next, let's discuss benefit eligibility. *Medically necessary* was the phrase used in some of the early riders. Lately, some of the states have balked at that and they want something more specific. One answer to that is to express it in terms of activities of daily living (ADLs). If the insured is unable to perform two or three ADLs, then he is eligible for benefits. The most common ADLs include: bathing, continence, dressing, grooming, eating, preparing meals, toileting, taking medication, transferring, and walking.

If you want to enhance your rider you could consider home health care, adult day care, or respite care. I haven't seen these too much yet, but it's certainly a direction that the marketplace is going. In fact, the treatment of long-term care is a developing area where there are now more providers which will increase the utilization. This will cause a snowballing effect and I'm sure that these features will be part of it. If you decide to get involved in any of these alternate services, you have to decide whether to use an indemnity or reimbursement approach. You might want to reduce the monthly benefit. For instance, home health care might be reimbursed at half the rate of nursing home confinement and you might cap the maximum benefit at a lower level.

Let's discuss exclusions, meaning conditions that you might not want to provide benefits for. The first is mental illness if there's no organic cause. This violates statutes in certain states and has caused a problem in approvals, but there's still a whole category of mental illness that is excluded. Mental illness is a vague area and to jump into it with a rider to a life product may be too uncomfortable. Alzheimer's disease cannot be excluded in almost all jurisdictions. I think that can be resolved outside the rider itself by, for instance, filing a statement with the regulators. However, the thinking is that AIDS should not be an excluded condition. Other exclusions might be felony, war and self-inflected injuries. I've seen it both ways -- 50/50 -- on whether these conditions are excluded or not, including the last groups.

The next group we'll look at is catastrophic illness or dreaded disease riders, and how they got to the United States in the early days. These riders were first sold in South Africa. I believe they are sold on a large percentage of policies there. They migrated to Great Britain in the mid-1980s. Finally, Jackson National brought it into the United States in early 1988, followed closely by Provident Life and Accident.

The form of the benefit, as with long-term care, can be as a rider or a policy provision. The base policy can be cash value life insurance or, unlike long-term care, a term product where the need is limited and the target market is not nearly as old.

Most companies don't restrict issue ages other than juvenile limitations, but a minimum age of 20 is popular. Maximum issue limits can go as high as 80. There's usually no maximum to how long coverage will be provided. Most of the companies won't cap the benefit expiry age unless, of course, it's on a term product.

The benefit typically takes the form of a single payment. It can be a percentage of the death benefit ranging from 10-30%. Some companies offer you a choice of levels, say 10% and 25%. The maximum total benefit we've seen is from $75,000-300,000. The $75,000 maximum is typically expressed as 25% of the death benefit, capped at a $300,000 policy. The reason behind the maximum depends on the purpose of the benefit. The legitimate purpose is to cover large medical expenses arising from a catastrophic event. But there could be all sorts of needs given a catastrophic event, so it's hard to know when the maximum amount is too much. I would say that the $300,000 maximum benefit is probably pushing it given medical expense levels right now.

What kind of events should you cover in a catastrophic illness rider? The most common are heart attack, stroke, cancer, coronary artery disease and renal failure. Organ transplant has been around for a few years and is getting more popular. Companies are experimenting with paraplegia, multiple sclerosis, Alzheimer's and blindness. I'm not too familiar with what is being provided right now with respect to AIDS, at least not in the United States, but we've seen an increase outside the states where they're not as concerned about it. Also, these riders can cover an extended nursing home stay by providing a lump sum if someone's been in a nursing home for a year, for example. This mixes the two concepts a little bit.

What describes an appropriate benefit to include? It should be subject to definite diagnosis, a real black and white situation where you know the event has occurred. For instance, coronary artery disease would probably not be a good description because of the gradations involved. It should be described in precise terms and be understood by the medical community. It should be accurate and non-ambiguous, but also understandable by the person buying the policy. Otherwise, the insured may be misled by his own interpretations or by the field force. The regulators are going to see to it that any ambiguities get interpreted in the insured's favor. Finally, it should be an impairment with enough statistics to enable us to study it, measure it and price it.

I'd like to go on to terminal illness riders. These provide benefits for conditions such as limited life expectancy or, say, an 80% chance of death in the next year. The rider could accelerate the benefit only on the policy to which the rider is attached or, as one company is offering, the rider could apply to any policy. If you're willing to pay the rider premium on a given face amount you don't have to lapse a policy and pick up this company's policy, which is an attractive approach. Typically, this rider has an explicit charge associated with it as opposed to the Prudential approach. The terminal illness rider is usually a percentage of the death benefit ranging from 25-50%. The other

category is the back-loaded-type product, such as Prudential's, that pays a discounted amount.

Those are the contractual relationships between this benefit and a rider. There are a couple of extracontractual routes that can be taken. One of them is a purchase offer where certain organizations might be willing to buy out your interest in a policy, especially in a terminal illness situation where a claim looks eminent. The offer would require medical evidence and may require the beneficiary's approval. The buy-out, of course, would be less than the face amount. What's the impact on the policy? If the offer is accepted, the purchasing company becomes the owner and beneficiary, and also becomes responsible for keeping that policy in force. The other version of this is the advance offer where the policy is not purchased away from you, but you settle for a reduced amount. Prudential of Canada has offered it mainly to AIDS victims to give them some financial support as the disease progresses. In a sense, it's a loan for less than 100 cents on the dollar with the face amount as collateral. If the offer is accepted, interest is accrued on this loan or advance. Again, it may require a beneficiary's approval, but the beneficiary designation is unchanged. There may be a residual death benefit if the advanced amount plus interest is less than the final face amount.

Some of these products are appropriate for annuity attachment as well. In the area of deferred annuities one benefit might be to waive the surrender charge upon impairment, nursing home confinement or a dreaded event. Catastrophic illness could be a trigger to receiving this. Internally, the benefit could be funded with an additional deposit by setting aside some extra money up front. Or, it could be a slice off the earned interest as a periodic payment to the company, holding down your cash accumulation in exchange for the cover. You could attach it to an immediate annuity as well. For instance, combined with the long-term care policy, it could result in a higher monthly benefit if you're confined in a nursing home.

You could combine some of these together such as a long-term care rider and a catastrophic illness rider. Also, on a catastrophic illness rider, you could round out your list of specific events with terminal illnesses. A lot of evolutions will be taking place in these riders.

Let's get into the area of marketability. Recently, I heard the term *back to basics* associated with product development and product directions. I don't think agents mind getting exposed to these riders, at least the ones that remember how to do need selling as opposed to investment product selling. The riders offer real benefits at an affordable price. The cost of the rider is marginal since you're not funding the entire nursing home benefit, but subsidizing the rider with the reduction in the death benefit. It's early enough in the life of these products so that the companies that introduce it now still have a window of innovation and a niche marketplace. The competition isn't there quite yet, so you can still set the rate where you want and possibly take some extra profits. Helping that along is the fact that the products are so different right now it's hard to line them up side by side and make direct comparisons.

What's the success been on the marketing of these products? Early results estimate that 20-25% of eligible life policies have one or more of these type of riders attached.

Getting a little more specific, Steve Lewis, President of First Penn-Pacific, gave a speech and shared some of his results which I'll pass on to you. In the states where available, their company was attaching long-term care riders to 32% of the under-age-60 sales, and for people 60 and over, the rider was going out with 68% by policy. That's probably the biggest success story at the moment. He went further to ask: Are these policies that we were going to sell anyway or are we selling a lot more insurance because we have this rider available? He looked at the states where the rider was and was not approved and found that below age 60 it doesn't seem to matter if the riders are there or not because they'll sell the base policy anyway. But for the older age market, people are buying insurance because of this rider's availability, so they're making a lot more sales. That's an overview of the marketplace right now with a little peek at what's ahead. Now, Jim is going to comment on the newest innovation in this series.

MR. JAMES M. O'CONNOR: Throughout the United States, the Prudential has been receiving terrific press in the media. In major cities and small towns, our new living needs benefit has captured the attention of the public, the press and our competitors. This particular product has been called a socially desirable expansion of the flexibility of life insurance. The Associated Press reported that this could bring a big change to our industry and *U.S.A. Today* said it's an idea whose time has come.

What is the living needs benefit? How did we get to where we are today with this new product? First, this is an accelerated death benefit product. This is a feature that advances all or a portion of the death benefit of a life insurance policy prior to the death of the insured. There are three main types of accelerated death benefit products in the marketplace. First, a dreaded disease product would advance a fraction of the death benefit if the insured had one of the big five diseases: life-threatening cancer, heart attack, coronary artery disease, stroke or kidney failure. The second kind of accelerated death benefit product is the terminal illness rider where a portion of the death benefit would be advanced if the insured had a very short life expectancy, such as 6 or 12 months. The last type is a nursing home rider. If the insured was confined to a nursing home for a period of time, the policy would pay out a fraction of the face amount, such as 2% each month. All three types were usually only available on new business and, in addition, they had an indeterminent premium structure with current charges and higher guaranteed maximums.

After looking at these three products what did we at The Prudential do? Just over a year ago our Canadian operations launched a pilot program that advanced part of the death benefit from policies that were owned by insureds who were terminally ill who were having premiums waived under the waiver of premium provision. They were not expected to recover from disability and were expected to die within the next 18 months. The company would usually advance one half of the death benefit at the time of the claim and set up a loan against the policy that would be repaid at the time of the insured's death. Interest was charged at the policy loan rate. We intended this program to be confidential but ended up receiving a lot of publicity when a friend of one of the program beneficiaries contacted a reporter. This program has continued but has remained on quite a small scale. The publicity that the company received from the Canadian experiment focused the interest of our field force in the U.S. on this type of a product. At the time we had been working on a way to accelerate the death benefit for

a number of months, but had not yet hit on the appropriate mechanism to pay these benefits. We had many ideas, but most of them had some major flaw when compared with our objectives for an accelerated death benefit program.

What were those objectives? First, we wanted to have a broad benefit. The Canadian program only worked for policies on waiver of premium. This is only a small fraction of the number of current and future insureds of the company. Second, we wanted to have a meaningful benefit. It wouldn't do if the accelerated benefit would not materially help the policy owner. Third, we wanted to be able to add the product to our in-force. We saw this as a reward to our policyholders for being valued customers and as a way for us to get immediate experience under the product. Fourth, we wanted any payments made to the policyholder to be tax favored.

To attempt to fulfill these objectives our initial design, a design that did not see the light of day, had three elements. It had a hospice benefit that would pay the death benefit out early if the insured was in a hospice and had six months or less to live. It had a nursing home benefit that would pay out the death proceeds early if the insured was confined to a nursing home for six months. And it had a vital organ transplant benefit that would pay 75% of the death benefit if the insured received a heart, heart-lung, liver, or bone marrow transplant. We intended for most payments to the insured to be made on a monthly basis -- six months for the hospice benefit and a number of years that was based on a sliding age scale for the nursing home benefit.

The manner we chose to determine that the benefits were meaningful was to make sure that the monthly benefits were large enough to do some good. Now, large enough is not a precise actuarial term, but it does define an objective that can only be met if we based eligibility for the benefit on policy size. We decided that a $25,000 minimum size was appropriate for this product. We also wanted to add the benefit to our in-force policies and we found the only way to fulfill this objective was to charge no premium for the benefit. This seems like a very selfless act but we feared that our in-force insureds wouldn't add the benefit if we charged for it. The benefit does have a cost through the discounting procedure which I'll describe later. We also felt that this type of design would get the benefit included in a maximum number of our new sales.

For the last of the major objectives, we wanted to match the tax-free status of death proceeds payable to a beneficiary. It was unclear last year that this objective could be met. It's hopefully less unclear now as Congress is working on the problem. Senator Bradley has introduced legislation in the Senate that addresses many of our concerns. It makes the terminal illness type of benefit tax free and answers a number of questions regarding adding this benefit to an in-force policy so that you don't do any harm to the policy under some of the alphabet soup tax legislation we've had over the last few years. His bill has over 30 cosponsors and there's a companion bill in the House. Maybe all we need now is some large tax bill to which it can get attached.

We had a number of other issues to consider. We wanted to protect our insureds from Medicaid. You will recall that one of the tests Medicaid uses for eligibility is an asset test, where most assets of the applicant must be spent before Medicaid begins payment. Medicaid cannot now put a claim on life insurance death benefits, but it can put a claim

on cash values. We felt that the only correct course would be for the policy owner to be the only one who could exercise the benefit, and that Medicaid would not be able to count the availability of our living needs benefit as an asset and, therefore, could not force any policyholder to claim the benefit against his or her will. We recognize that actual payments would be counted as part of any Medicaid calculations. The same concerns apply to other needs-based government programs on both the state and federal levels.

We also wanted to make sure that our insureds were protected from creditors. We recognized that the early payment of the death benefit might disadvantage a beneficiary. This is usually the person for whom the insurance was purchased in the first place and for a short time we considered having the beneficiary agree to any accelerated payments. After a lot of internal debate, we dropped this requirement because it would create rights for most beneficiaries that they do not now have. The only time we get the concurrence of a beneficiary is when the beneficiary is irrevocable. Finally, we were concerned what the effect of state regulation would be on a product like this. The product which we had designed really had not been seen before and that usually means all kinds of delays and questions. Due to the uncertain reaction, we visited with the insurance departments of nine major states to inform them of our intention to file this new product. We had not made this type of preliminary visit to a state insurance department before but felt we had to with a product as different as this one. Our early conversations with these departments and some evolution of our own thinking led us to make some key changes in benefits.

Our living needs benefit was born and announced at the end of January. The product advances the death benefit of a policy if the insured has a life expectancy of six months or less or if the insured has been confined to a nursing home for six months and is expected to remain there permanently. The hospice requirement and the explicit organ transplant option were dropped and we also added a single sum option to the payment of benefits. We will add the benefit to our in-force permanent and level term policies if the policyholder makes a positive election of the benefit. We have no underwriting requirements for our in-force, but there must be $25,000 in aggregate death benefits on the insured's life and we will group policies based on insured owner groups. We will add the benefit to new policies if the policyholder elects the benefit, if we get an acceptable HIV test, and if the policy is a permanent policy of $50,000 or more. Over age 60, we will offer the benefit down to $25,000. We will add the benefit at no premium cost and benefits can be paid to the owner in a lump sum or in monthly installments. Despite the fact that there is no premium cost, we can pay the death benefit early under this design by collecting a discount from the proceeds of any person who claims the benefit.

The benefit is computed as the present value of the future death benefit, less the present value of the future premiums that would need to be paid to support that death benefit, plus the present value of future dividends payable under the policy's current scale that are thus foregone by the insured. In short, we pay today's value of tomorrow's death benefit to the policyholder. Note that this last statement is quite simple, but it's probably the most important one of our whole design. The insurance company offers the insured the present value of the policy's death benefit in settlement of either all or a portion of the policy. Companies using this design must be free to determine this value.

The discounting mechanism is the method which the company uses to assure both equity and fairness. Equity must be maintained among those classes of policyholders who elect to have the benefit added to their policies and, ultimately, become a claim under the provisions of the benefit; those who elect to have the benefit added to their policies and never become a claim under the benefit; and those that elect not to have the benefit added to their policy in the first place. The discounting mechanism is the method by which the company determines and offers fair value to the policyholder. Any artificial constraint on the discounting process will put the ability of the company to maintain these aspects of its program in jeopardy. The company must be free to set, use and change the assumptions it deems appropriate in its product design when computing any of these elements.

To see one example of how payments under the living needs benefit program would work, let's look at a $100,000 Estate 20, which is our whole life policy of 10 years ago, issued to a male aged 65. If dividends were used to purchase paid up insurance, the current death benefit would now be just over $150,000 and the cash value would be just over $75,000. If the insured had a life expectancy of 6 months or less, a claim under the terminal illness option would produce a lump sum payment of just over $150,000 or 6 monthly payments of over $25,000. If we change the predicament of this insured to be one where he's now been confined to a nursing home for 6 months and is expected to remain there for the rest of his life, a claim under the nursing home option would produce a lump sum payment of over $117,000 or 60 monthly payments of about $2,200. The total of these possible payments shows the value of these options, especially, when you compare it to the cash value. The terminal illness option can pay out more than 95% of the death benefit. In some cases it's a lot more than 95%. And the total of the monthly payments under the nursing home option in this case is just over 85% of the death benefit. In other cases, the total of monthly payments can approach 100% of the death benefit.

If I can go back to state filing for just a moment, the benefit is now approved in 38 states. The filings in the other 12 states are moving ahead, some faster than others. Some states require new legislation or regulation. We ultimately expect approval in all 50 states, but feel that even now some of the approvals could lag as long as a year or more.

In any case, how have we done? We feel that we have created a broad benefit and a meaningful one. We are going to be able to offer this benefit ultimately to over three million of our in-force policyholders. Tax status is not yet settled but the developments are encouraging. We also believe that our lawyers have come up with an appropriate set of contract provisions to protect our policyholders from Medicaid. If we find that our contractual provisions do not do exactly what we thought they'd do, we have a fall-back provision that says anybody who's interested can remove the benefit from their policies permanently. We also think the same type of contractual language protects our policyholders from any of their creditors. Beneficiaries are not protected unless they are irrevocable. We haven't achieved the state regulation objective until all 50 states are approved. We still have a lot of work to do but feel that we've already made great strides.

We started with our product announcement in January. This was followed by the opening of sales for new policies in the middle of February and in mid-March we kicked off the first of the mailings to our three million eligible in-force policyholders. We do not yet have a lot of experience with the benefit. We've paid only a handful of terminal illness claims. We have not paid any nursing home claims. We have added the benefit to over 250,000 new and in-force policies and we're sure that this feature will benefit many more policyholders in the future. We feel we've taken a truly innovative and beneficial step with this product. We have added a new feature that maximizes the appeal and flexibility of life insurance allowing us to sell more. We've created opportunities for our field force to service both current policyholders and contact new prospects and, most importantly, we feel we've provided a valuable benefit to our policyholders.

MR. GOOTZEIT: I'd like to start talking about living benefit riders in the more general sense. We'll get away from the Prudential design, although we'll talk about that as it follows naturally. I'd like to pick up where Tim was going and talk about additional considerations in the adoption and implementation of the living benefit rider. The topics I'd like to discuss are regulatory activity, tax status, pricing and reserves, and other home office issues like administration, underwriting, claims and reinsurance.

Let's start with regulatory activity. The first topic under regulatory activity is statutory compliance. We're all interested to know what states are approving which products and some of the considerations of which we need to be mindful. The second is the NAIC Model LTC Act and Regulation which was adopted in December of last year. Some very important things happened with relationship to long-term care riders. Specifically, the third item is a new endeavor to work on an NAIC accelerated benefit guideline to resurrect something which was written by three state actuaries last year. And the fourth item is the Actuarial Standards Board. We'll talk about these one at a time.

The first topic is statutory compliance. Let's look at long-term care riders in those states which are approving them. That doesn't mean that these states are approving every single design which may come down the pike, but there is a design that each of the states will find appealing and will approve. The states that are not approving the long-term care riders right now are Washington, Minnesota, New York, Vermont, Connecticut, and New Jersey. There is movement, however, in several of these states. Minnesota, I believe, has proposed legislation, which will allow the department to approve the long-term care riders since the department currently feels that it doesn't have the statutory authority to do so. Governor Cuomo in New York has just introduced legislation which will again allow the department to approve these riders. However, I should caution you that it doesn't necessarily mean very much that the department has that statutory authority. New Jersey is not approving these riders and I'm not sure if there's any positive prognosis. But the number of states that are approving the long-term care riders is very encouraging. There are some prohibitive practices that you need to be mindful of. In particular, some of the gatekeeper provisions that were more common in the earlier long-term care riders and in long-term care policies currently are not allowable in many states.

Those states which are not approving catastrophic illness riders, and which probably have less hope for any movement, are Illinois, Pennsylvania, New York, Massachusetts,

Connecticut, New Jersey, Kansas and Minnesota. Their theory on the catastrophic illness riders is an extension of the old cancer policy theory which says that the covered illness(es) are very serious but there might be another illness which is equally serious that is not covered. Several major states that are not approving these riders are pretty vocal about it.

The terminal illness benefit, such as the one Capital Holding offers, has an explicit charge up front and then accelerates a portion of the death benefit, but without any discounting. These are approvable in many states, with the exception of Kansas, New York, Pennsylvania, Connecticut and Massachusetts. This is our understanding of the approval process right now. The *National Underwriter* had an article sometime last year whose thrust was that the states were dragging their feet in the approval of living benefit riders. However, I've been involved with this product for almost 3 years now and, considering that 3 years ago 51 jurisdictions were not approving any of these riders, I think the movement that we've seen has been nothing short of remarkable.

The next regulatory issue I'd like to discuss is the long-term care Model LTC Act Regulation which was adopted by the NAIC in December 1989. This is a less watered-down act and has a number of more appropriate provisions than the prior act adopted several years before. Let's talk about the provisions in order of importance. The first one is that long-term care riders are blessed. Early on, some of the states said they didn't have the statutory authority to approve these products. If the state adopts this regulation, that will go away, although it has already gone away in many states.

First on the list of prohibited practices is gatekeepers of all kinds. You can't have prior hospital gatekeepers. You can't have higher level institutional requirements before covering lower levels. For example, if you have a home health care provision, you can't condition the home health care on being confined in an institution prior to that. There are some restrictions on home health care, so it must be of a more robust kind. There's also quite a bit of discussion on postclaims underwriting and there's some sort of requirement that companies receive attending physician statements on older insureds. There is a lot of unfavorable press in the long-term care insurance industry about the way we have promoted our products and how people possibly weren't getting what they expected. *Consumer Reports* had a very unfavorable issue in the spring of last year. The industry had gone quite a bit of the way already towards policing itself, but we're now stuck with more regulation.

There is now a reserving methodology in the model regulation. It doesn't say very much. This reserving methodology is quite the same as New York Regulation 126 on asset/liability management which discusses the things to consider and how to conduct your business. There is no explicit reserving methodology in the model regulation, but it states the things you should consider. In particular, one of the detriments is that there's no valuation morbidity standard.

The next regulatory item I'd like to cover is the NAIC Accelerated Benefit Guideline. Donna Claire is from the Equitable and she's resurrected a new endeavor to get people to start thinking about this. Last year there were three insurance department actuaries from Illinois, California and New York who co-authored something which could have

had a restricted impact on the way our industry would be regulated with regards to living benefit riders. The industry seems to be taking the view that that wasn't appropriate and the draft which is out now has a more expanded list of product design features. I noticed, as an example, that the Prudential design is explicitly covered, along with catastrophic illness, terminal illness and extraordinary medical intervention. There is a new actuarial task force, whose main focus is supposed to be on reserving methodologies for accelerated benefits by themselves. There's a wide range of opinion on the appropriate reserve methods for these products.

The last regulatory item I'd like to cover is the Actuarial Standards Board (ASB). There is a task force on long-term care chaired by Bart Munson which is far along. The task force reports directly to the ASB, and is not a committee of the ASB. The draft is ready to be proposed to the ASB for possible exposure next month, I believe. It includes riders to the extent they need to be included and, in particular, in the actuarial standards of practice. This is an area where there's some disagreement on how we should be prescribing standards of behavior in the profession. In any event, it's high on the agenda of the ASB to get something out there that will encourage us to act responsibly with regards to long-term care because of all the unfavorable press. For example, I heard the Commissioner of Insurance from Arizona say that 80% of the complaints in the state of Arizona were because of long-term care products.

Let's jump over to tax status where not much has been resolved. Under tax status I have five categories posed as questions. First, when you receive benefits under these living benefit riders what is the tax status to consumers? What is the company taxation position? In particular, can you deduct the reserves from the definition of taxable income? What about Congressional (in)activity? What is the ACLI doing? What about the tax opinions companies have been resorting to, since not much has been resolved?

Let's talk about consumer taxation with regards to living benefit riders attached to life insurance. I believe that most companies are concerned with this and there are a number of converging issues, none of which are addressed directly by the existing regulations and legislation. The first one is the definition of life insurance. I'm mainly talking about living benefit riders that have a contractual benefit with explicit charges. Let's say, for example, a long-term care rider with explicit charges deducted from a universal life fund. Does the life insurance policy still get 101A treatment when the guy dies? Well, you might think, of course, the answer has to be yes. But that's a leap of faith since long-term care riders don't have any tax standing whatever in Washington. I don't think anybody in the industry would like to see us throw away 101A treatment on the life insurance. On the other hand, let's suppose that you have another kind of insurance, say your car insurance, funded from a universal life product, and every month your car insurance premium was deducted from the universal life fund. These two products, car insurance and long-term care riders, have the same tax standing with regards to life insurance, which is none. So every time that monthly deduction from your universal life fund was supporting your car insurance, you would have a distribution. You can extend that logic to long-term care riders which again has no life insurance standing. It may seem very extreme to say that we're throwing away life insurance treatment and getting unfavorable tax distributions, but I have heard it proposed by a lawyer from a very large mutual company. That's not their official interpretation but it is

a fear. Having said all that I don't think there's any fear that we'll be throwing away the 7702 favorable treatment.

Possibly a more important issue is what to do with guideline premium and seven-pay premium tests when you attach these riders. The narrow view is that you don't get additional guideline premium limits or seven-pay limits when you attach a living benefit rider. The ACLI has proposed that we do something more favorable than that. The last item is, what is the taxation event, if any, when the benefits are payable to the consumer? Long-term care riders are very similar to long-term care policies, so let's do an extension. What is the taxable event when the policyholder receives benefits from a long-term care stand-alone policy having nothing to do with life insurance? The answer is you don't know -- it's an unresolved issue. So, obviously when we try and extend this out to these other living benefit riders, taxation of benefits is still unresolved.

Let's just jump over to company taxation and, in particular, reserve deductibility. Last year, Revenue Ruling 89-43 stated that reserves are deductible from company taxable income for long-term care insurance. It didn't mention the kind of long-term care insurance, whether it was policies, riders, or anything else. Everybody's assuming that it will extend to all kinds of long-term care insurance provisions, regardless of how funded. So, the Treasury Department went halfway towards making this health insurance. It did not say anything about the consumer taxation which would go the other half of the way towards qualifying it as health insurance. I think it's a safe bet that LTC reserves are probably tax deductible. Regarding reserves on other riders, such as the catastrophic illness rider and terminal illness rider, there is no legislative history or any precedent to follow.

Since everything is unresolved you might think that Congress would be anxious to resolve these issues for the industry. There have been dozens and dozens of bills introduced that address long-term care insurance, living benefit riders and the Prudential provision. However, the ratio of bills introduced to bills actually enacted is something like a hundred to one. I think the one that stands the best chance for enactment is the one that will specifically cover Prudential's product because of its high profile. We'll probably be in limbo for a while until Congress can sort out whether or not it wants to take programs public, like long-term care and health insurance, or if it wants to promote them and keep them private. After that decision has been made I think we'll see a little bit more action. Do we deserve additional tax benefits which are explicitly promoted for us? I think we do, because they are insurance benefits and get away from the investment kinds of products that got us into trouble with Congress in the past.

I think the ACLI has done a good job putting together several task forces which made recommendations that were then carried to the Treasury in an effort to resolve all these unresolved issues. The recommendations would clarify all of these federal issues and more, such as whether or not long-term care policies can be part of the cafeteria plan and deductibility to employers. Treasury has the statutory authority to act in coming up with interpretations based upon new facts which were not around when the legislation was enacted. Treasury has not acted and I don't think anybody really expects them to do so. The only exception is the revenue ruling on deductibility of reserves for long-term care insurance.

Given all of the facts we have, many companies have resorted to tax opinions, which I think is advisable only because you can then say you've done everything that can conceivably be done. An important point is that some opinions on precisely the same kind of product designs don't coincide. For example, we see one company with a catastrophic illness rider getting a tax opinion on the taxation to consumers. You get another company with a catastrophic illness rider with another tax opinion about the taxation to consumers and lo and behold the tax opinions don't coincide. Having said all that, I'm not sure of the value of these opinions other than you're essentially doing all you can do and you can disclose the tax opinion to the consumer who can then consult with his tax adviser on how insurance might impact him.

Let's talk about pricing, in particular, claim costs and methodology. First, we'll discuss claim costs. For long-term care, the 1985 *Nursing Home Survey*, we believe, forms the best statistics from the general population data. The statistics are presented in a usable fashion by age, duration, termination rates, and so on. There are other surveys as well that deal with long-term care confinements, annual frequency rates, terminations, and so on. There is an SOA Committee on Experience Studies which is addressing long-term care. The long-term care study was originally planned for release in mid-1991, but we've had information that may not be met. In particular, there aren't that many companies that have reliable data and some of those companies may not want to display their data because of the possible proprietary nature. When the study does eventually come out, the information will be based on policies that have old and outdated provisions. Care must be exercised if you look at this old, outdated study and try and apply it to the new modern policy provisions.

If we turn to the catastrophic illness rider and look at the sources of claim costs there, the situation is a bit more rosy. The catastrophic illnesses are things like heart attack, stroke and renal failure, and, in fact, there are very reliable population statistics that indicate what the claim costs on these impairments might be. The sources include population data, medical journals, government studies, association studies like the National Association for Cancer, and other countries' experience on these products, particularly, South Africa and the U.K.

Let's say we now have this information which is generally population statistics. How do we then go about using it in an insured setting? First of all, we need to make the general to insured adjustment. There is a strong belief that there will be induced demand created when these insured products hit the marketplace in larger numbers. In fact, a number of things may occur. We now have something like 1.5 million policyholders of long-term care insurance. As that number grows, there may be some impact on the availability and the construction of new facilities as more and more people then find it in their means to make use of these facilities. Thus, this would be a positive increment. On the other hand, we'll need to apply a selection factor since there will be underwriting on these policyholders. They may tend to be considerably more healthy than the general population. The catastrophic illnesses covered are precisely the kinds of things we want to identify in the selection process. So at least the early years should have considerably better experience than the population. We have to be cognizant of these two off-setting factors. The third point is the interdependence of events. You may look at the raw data separately on heart attacks, strokes, renal failures and so on. The

catastrophic illness riders that our industry has only pays on the first of those events, yet the statistics may be double counting. For instance, maybe the same person has two heart attacks or a heart attack and a stroke. That particular individual statistic will find its way in as a multiple event. So we actually need a reduction from the sum of all these statistics for this interdependence.

Let's talk about methodology. How do you actually run a profit test now that you have statistics which are on the somewhat reliable side? First, we profit test the base life policy. Then we profit test the base life policy with the living benefit rider, because a number of the cash flows will be impacted when we add the living benefit rider. Claim costs impact the cash flows as well as reduce death benefits and cash values which are now available. The difference between the two profit tests with and without the rider is attributable to this living benefit rider. We have two methods which are dubbed the single and the dual population methods. The single population method uses averages for the entire group of in-force policyholders including the ones that have had the living benefit rider occurrence and the ones that have not. Under the dual population method the in-force projection is split into two separate bands. The first band would be the healthy people, those people who were in force and who have not had the living benefit rider claims; and a second impaired group consisting of those people who are in force on the life insurance but who have had the living benefit rider claims. You can have separate assumptions for mortality, lapse, and so on, for each of these groups. You want the aggregate assumptions to be approximately the same as what you would have had if the living benefit rider were not present. You do get different results depending on whether you use the single population approach or the dual population approach. The single population approach is advantageous because it's simple; the dual population approach is advantageous because it's more accurate. The choice of method depends upon the situation.

I have a few comments on reserves. Since the Model LTC Act and Regulation, I believe there is now a heightened awareness that reserves really do need to be set up. We must also consider other products besides long-term care riders, such as catastrophic illness riders and terminal illness riders. There is a very wide range of practices among those companies that have living benefit riders with regards to reserves. Larry Gorski, of the Illinois Insurance Department, noticed very wide reserving practices in the actuarial memos, going from no reserves proposed by some companies to very conservative and redundant reserves by other companies. He was the one who brought up the issue and somewhat forced the NAIC to put in the reserving section last year, which goes to the heart of this thing -- are reserves necessary? If reserves really aren't necessary and if we go through the exercise and try and calculate the reserves, the reserving methodology will show us that the reserves aren't necessary. I'd like to see us go through the exercise and convince ourselves that reserves are not generated by our method. Then we get into the calculation rules -- for example, what morbidity valuation method you use. Also there's the tax deductibility issue I covered before for long-term care, where it's somewhat more assured, versus other products which remain unresolved at the moment.

Let's talk about other issues including administration, underwriting, claims and reinsurance with a few comments on each. Starting with administrative issues -- it's been a long time since we've had to develop new products. I think the last one was universal life

insurance. I remember how we developed our universal life product. The actuaries and the marketing people got together and copied somebody's universal life product, then we filed it and gave it to the administrative people. They said it would cost us 16,000 man-years, so the cost was prohibitive. We didn't do a very good job in advance trying to figure out what would be the most efficient way to implement and design a product. I think we have now learned that there might be some decisions you can make on product design that don't really impact the marketability of the product, but would make your in-house administration people a lot happier. You should consider whether you want to use the rider or supplemental benefit approach in your administrative system. The adjustment method used when these benefits are payable can be an invisible administrative specification. Do you want to use the permanent lien approach or the partial surrender approach Tim mentioned before? I think these products will develop separate reserves that will be different by issue age and duration. Plus, this is now a rider to a life policy which could be a key administrative burden. Some additional items to keep in mind are that the sales illustrations and the annual report for universal life insurance will need to be modified. In particular, we'll need to tell the consumer what happens to his death benefits and cash values when payments are made.

The process of underwriting involves good selection and using as many underwriting capabilities as we can. We're in luck with selection by policy provision because no new benefits are created. We're simply advancing benefits already on the table. A number of gatekeepers are still permitted. There can be a waiting period; for example, the person has to be in the nursing home for 90 days. There are preexisting condition clauses which say that we can permanently deny claims that occur within the first six months if the insured needed to have medical attention six months prior to issue. Also, we can limit the covered events so that our underwriting process will be more successful. In addition, we can get more information for a life insurance policy with a living benefit rider than if it did not have the living benefit rider. We can ask special questions on the application although most companies do not. I think we need to focus on family history quite a bit for a catastrophic illness rider since heart attack, cancer and those kinds of things tend to run in families. We need to ask if there is other long-term care insurance in force since we don't want to have duplicate coverage. You need to make a decision about how you're going to treat substandard life insureds. You can rate the rider separately or you can decline the opportunity to add the rider in substandard cases. I think most companies right now are leaning towards the latter, and only adding living benefit riders to standard cases. The last point is, how are we going to attach these living benefit riders to in-force policies? If it requires underwriting, or an additional charge, it will be a little more difficult to attach to in-force policies than, let's say, the back-end-loaded Prudential design. But invariably you will get some demand to add it to in-force policies and you need to come up with a coherent design and plan on how you're going to accommodate those people.

Moving on to claims administration, when a person goes into a long-term care facility we need to make sure the facility qualifies as a long-term care facility or a nursing home in the jurisdiction that it lies in. When we look at the more experimental alternate services such as home health care, adult day care and respite care, the claims administration may be pretty tricky, especially for those companies which are primarily life insurance companies. There are some examples of how it may be difficult to administer these

kinds of claims with long-term care riders. We have the activities of daily living requirement. You'll get medical evidence that the person has flunked this test and you need to be in a position to judge if that's true or possibly counter with additional evidence of your own. The catastrophic illness rider will have a large gray area. We have precise medical definitions about what a heart attack is with the percentage of scar tissue on the heart, as an example, but that may not have been prominently featured in the promotional material that the consumer got. So if the insured has a general understanding of what a heart attack is, we may need to conform with that general understanding and adopt a claims administration process which is a little bit more generous. The terminal illness rider requires medical evidence, making sure that the condition actually complies with the contractual provision of terminal illness. It might be a limited life expectancy. Let's say the person is expected to die in less than twelve months. That medical evidence is very subjective and there will always be a large amount of gray information there.

Let's talk about reinsurance -- is it necessary for living benefit riders? This next point is key: It's very untidy to have one reinsurer on the base policy and another reinsurer on the living benefit rider. Not only is it untidy, I don't think it's being done and I certainly would not encourage it. So, if you're entering into this field and you think you might need some support, then you might look to your primary reinsurer as the first candidate for reinsurance on the living benefit rider. There are other questions about whether it's on a quota share or excess retention basis, and whether it's going to be priced on a YRT or coinsurance basis. The same kinds of reinsurance which are available on the base policy can be extended to the living benefit rider. It's neat if everything matches such as the retention and the structure as far as expense allowances or YRT charges.

I want to talk about marketability versus control and tie it all together. First, marketability. Why are these riders popular? First of all, it's fun for actuaries who are tired of tweeking universal life insurance. The living benefit rider offers real benefits at an affordable price. Properly motivated by the field force, I believe consumers will be excited by this product design. Another important reason is that differentiation makes direct comparisons more difficult. Now, there may be a company or two in this group that have heard from their field forces that their twentieth year cash values are inadequate. You'd like to deflect from that comparison and do something which makes direct comparisons more difficult. Adding riders is one way of doing this. And although it's going away, there's still an innovation aura left with these riders. Prudential has shown that you can pick up innovation even though you're later in the process, so companies still have an opportunity to be clever. We have some evidence of sales success if properly marketed. If improperly marketed, we've seen sales results close to or actually at zero. It takes a commitment from the company to market these riders well.

Now, on to financial control. There's no individual selection. If you buy a $100,000 life insurance policy you typically get the living benefit rider which is associated with that policy. You can't select how much of a long-term care benefit you want, what your waiting period is, or what your benefit period is. There are no new benefits. We're only accelerating benefits which are already on the table. The risks can be underwritten separately; for example, if you get a tricky underwriting situation, you can decline the living benefit rider. The last point is the most important. The risk profile of a living

benefit rider is much smaller than the stand-alone health counterpart. For those companies that are not in health insurance this might be an easy and controlled way to enter this kind of marketplace.

MS. BARBARA A. KELLER: I think Tim mentioned that not too many companies were including custodial care in these riders. If the states are requiring activities of daily living as gatekeepers, doesn't this, of necessity, imply that you're going to be covering custodial care?

MR. TWISS: I really haven't seen too much activity in that area, but I believe that the states are encouraging the substitution of ADLs for medically necessary since they want something a little more concrete. There could be the situation you mentioned, depending on the ADL list. For example, out of a list of six or seven ADLs two or more could look like a custodial situation.

MS. KELLER: Most ADLs are of a custodial nature. We do quite a few nursing home policies and more and more we're finding that our policies have ADLs in them and we're required to cover custodial care. I think that's been fairly typical for long-term care policies, but it was the first I'd heard of this applying to long-term care riders. Apparently, they're being held to the same standards now.

MR. GOOTZEIT: Yes, the long-term care riders are being held to the same standards. The new NAIC model will essentially require that custodial care be covered, but the model has not, as far as I know, been adopted in any states. However, once the NAIC adopts, a lot of the states will look to the model as the authority on how to adopt their program of approvability.

MR. BARTLEY L. MUNSON: I'd like to make an add-on comment and then a request. The add-on comment is with regard to the data collection on long-term care experience. There have been six companies so far that have contributed data. That is the update and I'm equally pessimistic about how soon we'll be able to publish in a traditional intercompany study sense. People, even the federal government, are keenly interested in what we're doing.

On behalf of the Actuarial Standards Board I would like to make a request, not of the panel, but of the audience. If all goes well, the task force will recommend to the ASB to expose, and we hope the ASB will vote to expose, resulting in the long-term care exposure draft. You should all receive the exposure draft and you'll have until November 1 to respond. We view this as an educational piece, not as a noose to hang actuaries and, certainly, not as a cookbook to tell us how to price and behave on long-term care. My plea is simply that many of you will care enough to read it and tell us what you think. As long as it's even reasonably constructive, we promise you a personal response and we will factor it into our redraft when we go back to the ASB and hope that they'll adopt a standard someday.

MS. CAROL A. MARLER: One of our reinsurance clients has been filing a long-term care rider and a couple of states have objected to the waiting period on preexisting conditions. Do you have any comments?

MR. GOOTZEIT: I'm aware that there are some states that will not permit the preexisting condition clause. My understanding is that it's a health provision so it can't be attached to a rider to a life policy. I find this to be a little unfortunate because we'd like to break down these divisions and crutches which in my mind are immaterial.

MS. MARLER: One of the states permitted it but shortened the period, I believe, from 60-30 days.

MR. PATRICK D. LUSK: My question is about these noninsurance insurance companies, such as, Grim Reaper Inc. Has there been any move to regulate them or to recognize the tax consequences of these companies purchasing a policy and essentially receiving the tax benefit while the seller receives a huge taxable gain on these policies? Also, there's the fact that they're not differentiating between the type of policy they're buying; whether term, whole life or universal life.

MR. GOOTZEIT: From what I recollect, originally, these organizations, which I think are 800 numbers operated out of garages, essentially bypass the entire regulatory process so that they're outside the insurance scope. The insurance departments got wind of this and tried to regulate them under the insurance laws and I believe that's still somewhat unresolved. Of course, there is some sentiment that these transactions are against public policy which is the main point. All of a sudden, I'm the beneficiary of a policy and the owner of a policy on a different life and my interests are served if that person dies fast. That's usually the reverse of the way we believe that the beneficiary should feel about the life insurance. Does anybody in the audience have any more specific knowledge about that?

FROM THE FLOOR: Some companies are refusing to acknowledge the assignment on a public policy basis which would be a real interesting legal situation.

I have a question regarding LTC premium. Can the benefits be either a feature or a rider? Are they more often guaranteed renewable or is it a noncancelable premium?

MR. TWISS: We're strongly recommending with the statistics as soft as they are and all the adjustments that need to be made from the current data to an insured life's group, that they be set up as indeterminate premium. I guess you could look at it as guaranteed renewable in a sense, but with room for adjustment up to limits.

FROM THE FLOOR: Are the reasons that there's a very long tale, the utilization severity rate is way down the road, and government can have a heavy hand in it?

MR. TWISS: Absolutely. Another concern is as these benefits become more popular and more nursing home beds are created, the utilization rate is a real unknown.

FROM THE FLOOR: We've currently been doing a lot of work on including individual dreaded disease riders on a regular group term life product. What we're primarily seeing is that it's being offered as a stand-alone product, and not an accelerated benefit. I wondered if any of you have any experience or if you've seen anything on the group side.

MR. GOOTZEIT: On the group side we've seen three or four riders with the terminal illness acceleration benefits. We're most familiar with only terminal illness riders on pure group term. It would be priced without explicit additional charge and I have not heard of a full benefit. I believe that in the U.K. there have been some dreaded disease designs on a stand-alone basis, but this is the first I've heard of anything in North America.

MR. O'CONNOR: I've not heard of any dreaded disease riders on a group basis, but I've heard of a couple of the terminal illness riders. Typically, there's a small added premium and you can use the same type of approach for group as we used on the individual side.

MR. MICHAEL A. HULME: Jim, it seems that adding the nursing home benefit to in-force life insurance policies would have a lot of systems problems. Did you have a lot of administration or systems issues to face with the monthly payout?

MR. O'CONNOR: Yes and no. The biggest administration issues on the in-force was stuffing millions of letters. The settlement of part or all of the policy is either into a lump sum, where administratively, the whole policy has disappeared, or, if it's a part of the policy that's settled, a proportionate reduction in everything is done. If somebody takes a monthly payout, we compute the benefit and ship the record down to our periodic payment center and then pay out a certain annuity. We don't have life contingent annuities on the payout side. So, yes, there are some administrative issues, but most of them are ones that we are able to handle without a whole lot of extra work for our systems folks.

MR. HULME: So you already had a system that handled the periodic payouts once someone started receiving the nursing home benefits?

MR. O'CONNOR: Yes, it's the same system that makes any of the payments under our settlement options or our annuities when they start the payout period.

MR. GOOTZEIT: I think there's a point that didn't connect. It's a conversion of a life policy to a period certain annuity, so once that conversion occurs, the life impact is gone.

MR. DAVID L. METZLER: You mentioned briefly some sources for claim costs on both the long-term care and the dreaded disease riders. We have a terminal illness rider and I was wondering if anybody had any insight on claim costs or if it's all still blue smoke and mirrors at this point. We can't find any sort of data to hang our hat on.

MR. GOOTZEIT: We have our own judgment but it's smokey. It tends not to be very financially significant, so as you refine your statistics the premiums don't seem to differ a whole lot. So the blue smoke seems to be sufficient.

MS. LORI A. KURTZ: As a reinsurer I think one of our main concerns on seeing all these long-term care riders come through the door is administration. We can do everything on a proportional to base reinsurance with no problem. I think the administrative problem that we have is on a long-term care type policy. A person can be

introduced into the nursing home, then recover, and then go in and out, in and out. Keeping track of the net amount at risk is a really hairy administrative problem. Do you have any solutions?

MR. TWISS: These are problems the direct side has to face, including the problem with the way the rider is worded. You're going to freeze it at a certain point and follow up with that and, presumably after an in-and-out situation, when you start payments the second time around, you're still going to look back to the 2%, for example, of the original. The question is how do you maintain that amount on your records? In other words, if the benefit is 2% of a $100,000 policy and you paid out the policy down to $80,000 and the person goes into a nursing home for the second time, you probably want the benefit level at 2% of the $100,000 again since it's a continuation. Again, it depends on if it's a restart or not. I'm not close to how someone has resolved that problem if, in fact, they have.

MR. GOOTZEIT: Lincoln has resolved this issue because they're anxious, as many other reinsurers are, to resolve these issues. I believe it's just a matter of thinking of all the strange things that can happen and coming up with an administrative solution to the strange things, making sure that they're agreed upon between the two parties. The interesting question that might come up on the reinsurance or even on the direct writing side is, what happens if you pay out 100% of the death benefit? Let's suppose the direct writer does not reinsure the long-term care benefit, but it does reinsure the life insurance policy. Then you pay out 100% of the death benefit so the policy disappears. The direct writer can never recover because he's going to lose contact with that individual and not know when he dies. You really have an administrative burden of keeping track of that individual.