RECORD OF SOCIETY OF ACTUARIES
1989 VOL. 15 NO. 3B

TERM INSURANCE DEVELOPMENTS

Moderator: MICHAEL PALACE
Panelists: NORMAN E. HILL
DONALD P. MAVES
H. MICHAEL SHUMRAK
WILLIAM R. WELLNITZ
Recorder: EILEEN M. COTA

- o Product design trends
- o AIDS considerations
- o Reinsurer's support or lack thereof
- o Recent statutory developments (Guideline XXX)
- o Nontraditional term products

MR. MICHAEL PALACE: I am responsible for the valuation of traditional products for Transamerica Occidental Life in Los Angeles. Our first speaker will be Don Maves, and he will be talking on recent statutory developments, specifically Guideline XXX, as I believe it is known in the industry. Don has over ten years of experience with Federal Kemper, and he has devoted so much time to this issue of Guideline XXX that I was surprised to find out he has other responsibilities. He is responsible for tax and financial reporting.

The next speaker will be Norm Hill. Norm has been a partner in two accounting firms, and a CFO in a major insurance holding company. He is now President of National Actuarial Consultants, which specializes primarily in mergers and acquisitions.

After Norm, Bill Wellnitz will be talking on reinsurance support or lack thereof. Bill is Vice President and Chief Actuary for the Reinsurance Line of Transamerica Occidental Life in Los Angeles, and he comes to us with 16 years of experience in the industry, the last two at Transamerica.

The last speaker of the panel will be Michael Shumrak. Mike is President of his own consulting firm and is primarily a management consultant to insurance corporations looking to diversify into alternative distribution systems, such as direct response. Mike was also the founder and the first chairman of the Nontraditional Marketing Section.

Now that we've met the panel, I'd like to introduce the first speaker, Don Maves. When I was asked to moderate this panel on term insurance, being the valuation actuary for the traditional block, my thoughts immediately flashed back to the valuation system where we segment our business into term and permanent. At Transamerica we don't have much term insurance. We stopped selling term insurance way back in the early seventies. Then I realized we have sold many tens of billions of a product called graded premium whole life -- and even though it smells like a rose, and looks like a rose, we call it a violet. In a sense, that leads us right in to the topic, because there are some regulatory forces at work which would like to change our definition back to what it looks like and smells like. So Don, give us an update on Guideline XXX.

MR. DONALD P. MAVES: There is currently a vigorous debate within the life insurance industry about the proper level of statutory reserves on individual term insurance and graded premium whole life insurance. I will give you a short historic perspective to set the stage for the current debate. The genesis of most, if not all, of the actuarial activity of the National Association of Insurance Commissioners (NAIC), is its Life and Health Actuarial Task Force (LHATF), sometimes known as the Montgomery Committee, for their chairman, John Montgomery, the Chief Actuary of the California Department of Insurance. This task force is composed of actuaries of a number of state insurance departments. It generally meets four times per year. Those meetings are usually open to interested parties, its minutes and agenda are published, and those publications

are available if one is on the mailing list. The LHATF provides various NAIC committees with advice and recommendations, a number of which have led to NAIC Actuarial Guidelines.

In December 1984, the NAIC adopted Actuarial Guideline 4, an interpretation of the Standard Valuation Law entitled "Minimum Reserves for Certain Forms of Term Insurance." Guideline 4 only applies to insurance with all of the following characteristics:

1. It is term life insurance.
2. There are no cash values.
3. The policy owner has the unilateral right to maintain the insurance in force until the stated expiry date, by paying the required premiums.
4. The required premiums vary during the term of the policy.
5. The premium rates are guaranteed until final expiry.
6. The valuation mortality is 1958 CSO.

Guideline 4 suggests two reserving approaches. The first is the unitary approach, in which the policy is treated as a varying premium policy up to the stated expiry date. Thus, for example, an annually renewable term policy that is renewable to age 70 becomes a modified premium term to 70 for purposes of this guideline. This approach requires the appropriate deficiency reserves, which may be zero, to be held. However, the unitary method is acceptable only if the company can demonstrate that the actual reserves are of the same general magnitude as those that would result from the second approach.

The second approach is nameless, but it segments the policy into the current and future parts, defines reserves for each part, and sums such reserves to get the total reserve. The current period runs for as long as the gross premiums remain level (which is not necessarily the same period as the renewal period). The reserve for the current period is calculated on the basis of the applicable mortality, interest, and method specified in the standard valuation law and it includes any appropriate deficiency reserves. Of course, the deficiency reserves are based upon the current period level gross premiums only.

The reserve for future periods is the present value of the excess of the "test" premiums for future level premium periods over the respective gross premiums. Any negative excess (which may sound oxymoronic) is treated as zero. The "test" premiums are calculated on the basis of 4.5% interest and the 1980 CSO mortality table with select factors, even though you may not be using that table to value the basic products. A company may substitute the 1980 CSO smoker and nonsmoker mortality tables with select factors for plans of insurance with distinct rates for smokers and nonsmokers.

Guideline 4 also discusses appropriate reserves for reinsurance assumed, the appropriate credit, if any, for reinsurance ceded, and considerations relating to the adequacy of reserves.

Here's a brief description of the reinsurance requirement. If the reinsurer has the right to raise premiums at least to the level of the net premiums, then the reinsurer does not have to establish deficiency or additional reserves. However, the ceding company cannot then take credit for any deficiency or additional reserves ceded.

If the reinsurer does not have such right to raise premiums, then the reinsurer should set up reserves according to the guideline, and the ceding company can take credit for that.

I do not recall this guideline generating much controversy at the time of adoption -- certainly not at the intensity level that the current debate has reached. There are a number of reasons for that.

First, many policies that were competing in the term market at the time were actually whole life insurance. As Michael has mentioned, they were known as graded premium whole life or increasing premium whole life. There were other names for them also. These types of policies had premiums and benefits extending to a high age, typically 100, with an endowment for the full face amount at 100. Thus, they were not term insurance and not subject to the guidelines.

Second, policies that had cash values were not subject to the guidelines.

Another mitigating reason is that many companies contractually reserved the right to change gross premiums, but never to raise them above stated maximum rates. These were the products with two

scales of rates -- a current or illustrated scale, and an ultimate guaranteed scale. Because the statutory reserves were based upon the guarantees existing at issue, the ultimate guarantees could be set high enough to minimize or eliminate any reserves required over and above unitary-based reserves.

The final reason is that many of the policies in the marketplace at the time were valued using the 1980 CSO mortality tables, and thus, were not subject to the guideline. One of the requirements I mentioned was that the company value the policy on the 1958 CSO basis, even though a 1980 CSO variation could be used for the reserves after the current period. So if the policy initially was valued on the 1980 CSO basis, the guideline didn't apply.

In 1988, the NAIC LHATF began to consider an update to Actuarial Guideline 4. This update was given a temporary designation of Guideline XXX (triple X) where the XXX represents not the number 30, but merely a convenient reference that would be changed to the actual number if adopted. Actuarial guidelines are generally numbered consecutively as they are adopted. As of December 31, 1988, there were 24 such guidelines, with Guideline 9 being recently split into two parts -- 9A and 9B. The reason I mention this is because there has been some confusion in the past among some people, including myself, thinking that XXX actually meant 30 (that it was a roman numeral 30) and that we had missed some guidelines along the way. That's not the case, however, as I was relieved to learn. I have heard this guideline referred to as "X-X-X," "triple X" or even "30," notwithstanding what I have just described. In fact, I heard one person refer to it as triple cross. I'll try to be consistent and use term XXX (triple X).

What were the motivations and concerns behind XXX? I believe that there are three primary perceived problems that the regulators want to address.

Their first concern is solvency. The term insurance market is highly competitive -- and when I say the term insurance market, I mean these graded premium whole life products also. The regulators fear that over-aggressive pricing will force some insurers to use some of their surplus to support the guarantees made in the product, perhaps even to the point of insolvency. Certainly the savings and loan industry debacle has had some, perhaps subconscious, effect. Insolvencies in any industry are costly, messy, time-consuming, and just plain bad for the public image of even the well-run companies, especially in an industry such as ours which relies on long term stability and security as being the key elements of our product.

The second concern is equity between persisting and lapsing policyowners. Many of these products develop negative terminal reserves and cash values for many years after issue. The absolute value of such negative reserves and cash values can exceed the death benefit many times over. It's not unusual to see a policy with a cash value of negative 2 or $3 thousand, or a terminal reserve of the same magnitude per thousand. (That sets some regulators' eyes rolling, and probably was part of the genesis for this activity.) Thus, a persisting policyowner can experience severe negative amortization of the initial reserve in cash value expense allowances, especially when compared to the respective expense allowances for a newly issued policy for a policyowner of the same attained age.

This leads into the regulators' final major concern -- that of manipulation and illogical results. By tinkering with the level and slope of its premium scales, a company may be able to set the reserve and cash value levels to be virtually whatever it desires. At issue, there is what some people refer to as the "collectability" of premiums. For example, there are policies in the marketplace today with guaranteed gross premiums in excess of $800 per thousand at attained ages of somewhere between 80 and 100. The proponents of the noncollectability theory would then argue that nobody would pay such a high premium, that obviously it was that high only for the purposes of decreasing reserve and cash value levels, and therefore, it is purely manipulative and should be regulated.

How did the regulators propose to answer these concerns? I will describe XXX in its latest form. It has been changed since its original appearance, but not substantially so.

Guideline XXX only applies to insurance with all of the following characteristics:

1. Life insurance issued on or after the operative date of the 1980 amendments to the Standard Valuation Law.

2. Premiums or benefits or both are not level.
3. No cash values are guaranteed during the first ten years of the policy.

Thus, as you can see, the application is much broader than Guideline 4, covering most term insurance and many permanent plans, such as the graded premium or increasing premium whole life plans as we discussed earlier.

Guideline XXX proposes three reserving approaches. The first is our old friend, the unitary approach, just as in Guideline 4.

The second method now has a name. It's called the renewable term approach, and it bears some similarities to the second approach of Guideline 4. The policy is again segmented into periods during which the gross premiums remain level. A base reserve is held for the current period, and it includes any appropriate deficiency reserves. Additional reserves for future periods of level premiums are the present values of the respective excesses (where such excesses are not allowed to be negative) of the net premiums over the gross premiums. The net premiums in this case are based upon the minimum standards specified in the Standard Valuation Law.

The third approach is called the unified approach because it is intended to combine the first two approaches. This approach defines the term "test modified net premiums," which must satisfy the following conditions:

1. They are based upon the minimum mortality and interest standards specified in the Standard Valuation Law.

2. They must generate nonnegative terminal reserves at every duration.

3. Subject to Condition 2, they must be level over every contract period where the gross premiums are level.

4. A level premium period must be combined with the preceding level period if the unitary approach, applied to the combined period, would increase the terminal reserve at the end of the preceding period. Over such combined period, the test modified net premiums must be a uniform percentage of the respective gross premiums.

Once the test modified net premiums have been calculated, the reserve can be defined. It is the present value of future guaranteed benefits minus the present value of future test modified net premiums, except that any test modified net premium is replaced by the respective gross premium, if that gross premium is less than the respective test modified net premium.

Guideline XXX also discusses reserves on reinsurance assumed and ceded, and the considerations regarding adequacy of reserves. It's a little different from Guideline 4. If the reinsurer has the right to raise premiums to at least the level of the net premiums, then the reinsurer is not required to substitute gross premiums for net premiums in the calculations of reserves. Also, the ceding company may not take credit except to the extent that it can raise premiums. Otherwise it's about the same as what Guideline 4 says regarding reserves on reinsurance and adequacy of reserves.

When this proposed guideline first came out, in the middle of 1988, the industry response was virtually nil. A few companies that had products that would have been affected by XXX responded to the LHATF initially, and also alerted other companies believed to be affected. As the word spread, a torrent of comments was generated, most of which were incorporated in the various sets of minutes distributed by the task force. The general, but not universal, feeling was that XXX in its current form was fatally flawed for a number of reasons.

The first reason, a major belief held by the companies affected most severely, is that XXX, rather than addressing its solvency concern, causes the incidence of the additional reserves to be exactly the opposite of what solvency would require. The solvency concern is that at some point in the future, the persisting group of insureds would be a substandard group. The expectation is that the steep premium increases on many of these products will prompt healthy lives in the group to seek to replace their insurance -- either internally through reentry, requalification, or reversion, or externally by replacing the current policy with another company's policy that has select rates. In fact, some people on the panel have mentioned that that's what they've done with their own

policies. I also have done that. Nonhealthy lives will not be able to do so and, thus will have to keep their insurance in force. If in fact this expectation is realistic, it suggests that additional reserves should start grading upward from standard reserves at issue until some substandard type of reserve is reached at an as yet undefined point (perhaps where the substandard population reaches its greatest degree). However, under XXX, for example on a graded premium whole life product with an initial guarantee of "n" years on a current premium scale, the maximum additional reserve will typically occur at issue. Then it will grade off to zero or something close to it at time "n," with little additional reserve required after that time. So you see you can start off with a higher reserve and go to zero just at the point where you think you're going to have the substandard lives remaining.

The companies writing this business are also concerned that the onerous reserves required by XXX at issue will severely restrict the availability of these products in the marketplace, a marketplace that has shown that there is a strong demand for these types of products. I will give you some examples using two actual policies issued by my company. These policies are graded premium whole life products. One series has the current scale at issue guaranteed for five years, while the other has a ten-year guarantee. I'm using both sets of guarantees to show you the sensitivity of XXX reserves to the guaranteed period.

Both are for a 45-year-old male nonsmoker. This example is specific to my company, so the magnitude and direction of the reserves may not apply to yours, but I just want to dramatize the effect of XXX upon these types of products. The product with the five year guarantee has a unitary mean reserve in the first policy year of approximately $1 per thousand, and the additional reserve that would be required by XXX is approximately $4 per thousand. The additional reserve for the product with the ten year guarantee is between $7 and $8 per thousand. So you have a factor of about five times the reserve for the five year guarantee and eight to nine times what you're holding now for the ten year guarantee.

Many companies believe that XXX is a de facto form of rate regulation. Because the market demand for these products is strong, companies, in order to make the products available without severe surplus strain, may have to make the products look less attractive to the consumer.

Retroactivity is also a cause for concern, because the way the guideline is written makes it applicable to in-force business. This would have a severe impact on the surplus of many companies.

Many actuaries are also concerned that XXX, by imposing an arbitrary and harsh standard, moves opposite to the direction in which the profession seems to be moving -- a direction that emphasizes cash flow testing, the responsibilities of the valuation actuary to use his judgment in setting appropriate levels of reserves, and sensitivity testing.

One final major concern is that the reserve imposed by XXX would not be deductible for federal income tax purposes.

I would like to give a brief summary of what is currently being done to try to solve all the concerns to the satisfaction of all the parties. In June of this year, the LHATF appointed a committee under the aegis of both the American Council of Life Insurance and the National Association of Life Companies. The charge to that committee included the following items:

1. To examine the current practices and methods used to determine minimum statutory reserves for certain forms of life insurance with nonlevel premiums or benefits.

2. To examine the current practices and methods used in determining the overall adequacy of statutory reserves for such products to make good and sufficient provision to meet future obligations.

3. To develop recommendations with respect to consistent and appropriate interpretation of the Standard Valuation Law as it applies to such products.

4. To develop recommendations with respect to the establishment of actuarial standards of practice for determining the overall adequacy of reserves for such products.

5. To develop recommendations with respect to the appropriateness of the current statutory mortality standards.

Note that the last point is not specific to the term and graded premium life policies that we're talking about.

The committee has spent a great deal of time trying to determine appropriate levels of reserves on five generic policy types, without regard to the current legal requirements. The generic types are the following:

1. Ten year level term, followed by ART rates.
2. Fifteen year level term, followed by ART rates.
3. ART.
4. Graded premium whole life.
5. Increasing premium whole life.

The difference between the last two is that one of them levels off eventually, at a high attained age.

All of the types listed above have gross premiums that are best described as select. In other words, they are not select and ultimate -- they don't grade into an ultimate final rate. Each issue age has its own unique set of premium rates for each of these products.

The committee has tested various assumptions regarding: 1) the degree of "excess" lapsation; 2) the percent of the excess lapsers that have been able to qualify for select rates at the date of lapse; and 3) the degree of excess mortality in the persisting group of lives.

I must make some general comments about these assumptions.

What do I mean by "excess" lapsation? There is an implicit, or base, lapse rate inherent in all inter-company mortality studies. The committee believes that lapses in excess of the inherent rate will occur, because of the premium increases built into these products. Thus, we have tried to relate the excess lapse rate to the percentage increase in gross premiums from year to year. It's rather difficult. We don't really have much experience, and the experience we have doesn't necessarily lead us to one type of rule. So we're still in the experimentation stage as far as what's the appropriate assumption.

Going to the next assumption, a percentage of the excess lapses will be able to requalify for select rates. That percentage obviously is going to be somewhere between zero and 100% and we're testing various alternatives. I don't believe that the percentage will be 100%, for a number of reasons. The original writing agent may not even be in the business. A 100% ratio would imply that all the insureds have perfect knowledge of their insurability, sort of like the efficient market theory of the stock market -- the efficient market in insurability, I guess we could call it. It's hard for me to believe that every person who is hypertensive, for example, is aware of his condition. Also another major factor would be just plain inertia. Some people buy their policy and put it in a safety deposit box, pay the premiums and forget about it, regardless of what the premiums are.

Given the degree of excess lapsation and the percentage of "select" excess lapsers, one can solve for the degree of excess mortality in the group that persists. The committee has used a technique described in a Canadian valuation technique paper.

One of the problems is that experience on these types of products is heavily weighted towards the early durations, before the assumptions have had a chance to manifest themselves. The committee is not yet in agreement on what the appropriate assumptions should be. It may ultimately recommend testing a range of assumptions.

Once the committee has agreed upon the appropriate pattern and general level of reserves, the next step would be to determine the statutory methodology that essentially reproduces that appropriate pattern and level. Unfortunately, reliance upon the concept of the valuation actuary is not appropriate at this time because the LHATF, the Montgomery Committee, believes that the valuation actuary is a long-range direction while their problems demand a solution in the

short-term. (I'm not sure they believe the valuation actuary will ever happen.) Therefore, there will probably be a formula-type minimum statutory reserve for these products, at least in the short term.

This committee made a preliminary (and I must emphasize the word preliminary) report to the LHATF a few weeks ago. The only firm conclusion that could be drawn was that XXX does indeed produce inappropriate patterns of reserves in many cases. I believe that much progress has been made; however much remains to be done in a relatively short period of time.

One of the things that we're focusing on now is that it's not necessarily enough just to meet minimum statutory standards. The valuation actuary, and the pricing actuaries, too, are going to have to be aware of this. We must take a look at what is the appropriate level of reserves to meet our obligations, not just to meet the statutory minimum requirements. So we'll require not only a formal approach, but ultimately some kind of judgmental approach.

MR. PALACE: I should just mention that, to be honest, our company was one of those that was awakened by Don's efforts on this topic. I'd like to introduce Norm to carry us through with the product design trends and AIDS considerations.

MR. NORMAN E. HILL: I'm going to discuss first the question of product development and what I see as the trend among aggressive term writers in the industry. The level of gross premiums is very competitive. Let me give you an example from one company, just a typical situation. A male preferred nonsmoker, age 45, who buys a policy with ten year level premiums, on a ten year term basis, can expect to pay somewhere around $2 per thousand. These premiums are the current premiums sold by the company. That's the typical situation, where there's a set of higher guaranteed premiums and the company does have the right to raise premiums if market conditions and other assumptions dictate.

It might seem strange, from one point of view, that premiums for term insurance would be so competitive, because certain negative events did take place in the early 1980s (and the late 1970s) for term insurance. Revertible term, the type of term insurance that allowed reentry at various points (subject to underwriting acceptability), and thus lower rates, did cause losses to various insurers and also to reinsurers. These losses on revertible term were probably due more to the lapse risk than they were to mortality, but the losses did take place. Another reason why you might be surprised at the low level of premiums is the higher cost of reinsurance which is generally true. And finally, another negative situation that exists is greater acquisition expense (since so many companies require blood tests which they didn't before), usually at a level of around $100,000 policy size.

One change that has taken place, even with these low gross premiums continuing, is what I call less emphasis on the reversion or reentry benefit. It is still there for many policies, but it seems to me it doesn't become available, often, until the tenth anniversary; whereas I saw policies in the early 1980s that allowed it at year three or year five. So I think there are some restrictions on the right to reentry.

Another change that I see is that there's more of a tendency to sell premiums on a level basis for a certain period of time. In other words, instead of ART from issue, with premiums increasing every year, there's a tendency to have premiums level for some period, perhaps five years or ten years. Afterwards, premiums will often show an increase annually, unless of course, some type of reentry option is elected by the policyholder.

One other key characteristic that you see is rate guarantees beyond the current year. These rate guarantees may last for five years, or often ten years. So the competitive premiums that are sold are often guaranteed for some period of that caliber.

Another change that I see, and I think it is fairly recent, is the existence of a superselect or a preferred underwriting class -- carving up the standard class into a run of the mill standard and a superselect standard. The underwriting requirements for an insured to qualify for preferred do vary by company, but generally there are requirements such as no private pilots, no hazardous avocations, definitely normal blood pressure and low cholesterol, also no history of being a drug addict or of alcoholism. The percentage that will wind up in the preferred class also varies by company. I know of one company that only expects a small percentage to qualify for superselect,

say around 20%. What this means is that the 20% are nonsmokers by definition, and if the total nonsmokers are about two thirds, you have 20% superselect, 46% standard nonsmoker, and the remaining one third would be the smoker category.

There are underwriting and marketing consequences from this approach to the superselect class. You have the agent that's on the hook. He has an applicant, and the applicant, if he thinks he's in good health, generally expects that he's going to be preferred risk and to get the lowest rate. The agent will generally push for the applicant to be in the preferred status. If he's going to be rated on a standard basis instead, it's still a favorable rate. But the agent has to go back to the applicant and explain to him that he's going to have to pay somewhat more, maybe 25% more, because he doesn't qualify, for one reason or another, for the preferred status. I have heard complaints also from underwriters about the existence of the preferred class. It often leaves them less leeway, because the requirements for the superselect status are often quantitative in terms of a certain weight target, a certain cholesterol level, a certain blood pressure level. And that doesn't leave as much leeway as there used to be for the underwriters' professional judgment. Some would say this is a good thing, some would say it is a bad development.

All companies try to include in their policies what we call bells and whistles, or certain special features, for marketing reasons. One thing I have seen is what is known as a 10% benefit advance. If the insured is diagnosed after issue as having a fatal illness that may drag on for two or three years, he has the right to request 10% of the face amount payable immediately.

Another feature, going back to the question of preferred or superselect versus the standard, is that often the standard premiums will equal the preferred premiums for the first two years, and then they will go up perhaps 25-30%.

I should have added that one of the characteristics that might lead people to question why there are such competitive term rates is the question of AIDS and the AIDS risk. It wasn't too long ago, 1987, that we saw a lot of very grim predictions being made for what was in store for the insurance industry and claim levels. We saw very high, in the range of $50 billion to $80 billion, of AIDS claims being projected for the entire industry; and, relatively speaking, the level of AIDS claims was predicted to be higher for the term writers. The reason for this more grim picture being painted for the term writers was the greater likelihood of antiselection from those who buy term, figuring they'll only pay premiums for a short time. The term policies generally don't have the opportunity to build up much in the way of reserves, and term insurances are generally nonparticipating so there's no ability on the part of insurance companies to vary dividend scales. However, it's still only two years down the road -- and our observation period has a ways to go -- but mortality for term writers, as far as I can tell, has been good. Although AIDS claims have not been high for either permanent or term policies, AIDS claims for term insurance, relatively speaking, have been higher than for ordinary life.

I emphasize that the AIDS experience is likely to show sharp variances by company even among term writers. These variations by company, of course, depend on the area of marketing, whether you sell to individuals or to families, and so on. The average age varies as well. I know one company (largely a term company) whose AIDS claims last year were about 1.8% of total claims. I know another company, also in large part a term writer, whose claims were higher -- about 3%. When you look at these two companies, there's a likelihood that the reason for the difference would be the primary area of marketing, but it would take more detailed analysis to pin that down. But percentages such as 1.8% or 3% are higher than the ACLI overall industry percentage that they compiled for 1988, where the individual life AIDS claims were a little over 1% of total claims. So AIDS claims were about $135-136 million -- that's both term and permanent.

The industry, in facing the AIDS risk, and still selling very competitive low term premiums, is relying on elements such as the right to raise premiums (up to the level of the guaranteed set of premiums). I think the industry is also relying very heavily upon the tighter underwriting, in terms of blood tests. I don't think you can overemphasize the importance of blood tests for the industry, for a couple of reasons. With a threshold of around $100,000 (and there are companies that require blood tests on every application), it doesn't protect the company against policies already issued, but I think it does provide deterrents for people who may be AIDS victims from applying for additional insurance, or for insurance for the first time.

But even beyond AIDS, there's been another benefit to the industry which helps mortality -- provides I think very considerable protection -- and that's the additional information that companies are receiving from blood tests. This may not have been intended originally, but the right to test the blood, besides the particular portion for AIDS, is giving invaluable information to companies and underwriters in terms of drug usage, alcoholism, and also smoking.

Let me conclude by saying that term insurance is being marketed very aggressively. This does not say that profit margins are what the companies would like them to be, but, so far at least, the experience in terms of mortality has been favorable, and I think companies are generally satisfied with it.

MR. PALACE: Introducing our next speaker, I'd just like to mention an episode that occurred years ago when I was first in the industry. I bought my first term policy. It was, I think, an old traditional ART. After a year or two, my friendly agent came over and said "Guess what? You have this increasing premium, but you can now requalify and get another policy from a different company." And so I started, probably on an almost annual basis, exchanging policies. I suspect I have had eight term policies in about 10 or 11 years, all based on the lower first-year rate, and each year it seemed that rate was going down and down. Even though from the consumer's perspective, in the short term, that may have been something very positive for them, from the company's perspective, this obviously was not a healthy situation. It was a few years after that, when I got into a small company that was selling a lot of this business, I started looking at some of this from a pricing perspective and started to understand what was happening. Even though, on a direct basis, we were essentially a not for profit organization, the miracle of reinsurance at that point was turning us from a not for profit into something that looked a lot more respectable. I'm sure things have changed in the reinsurance industry since then, and I am sure Bill will shed some light on this for us.

MR. WILLIAM R. WELLNITZ: The topic which Michael asked me to address is described as reinsurers' support, or lack thereof, for current term products. I was tempted to take so direct and simple an approach to that issue that I wouldn't even need to stand up. Clearly there is support. What option do we reinsurers have but to reinsure your business, or get out of the business? And it really is black and white. But frankly, that would fail to communicate my sense of the evolution that is taking place in the reinsurance marketplace. In preparing for the panel, I spent some time talking to my associates in the reinsurance community, within Transamerica and with consultants and our competitors, trying to get a sense of what issues come to mind when we address the topic of reinsurance and current term products. I had a fairly enjoyable series of conversations commiserating with the others about the short product life cycles, increasingly complicated underwriting classifications, the changing dynamics of the reinsurance purchase decisions, etc. And I have my whole list of things here that I can just run through, but that wouldn't capture the sense of what I think is really important in talking about the reinsurance marketplace. I really did struggle with how to try and get that sense across. I think this series of two images, if I could draw them for you, might help.

Not so many years ago, you can imagine the path to success for a direct writing life insurance company as being straight, smooth, a bright sunshiny sort of scene. If you needed a reinsurer, you probably would pick the reinsurer that you enjoyed the most to be around, the people that made the trip most pleasant for you. The lay of the land was pretty apparent. Even if you couldn't see quite over the horizon, you knew, based on the path that you already walked, pretty much what you were going to expect to find. It was a pretty straightforward life.

Well, it comes as no surprise that the world is very different. The path is no longer straight. It certainly isn't smooth. Where it had been sunny, it is now pretty much shrouded in fog. There are potholes out there, and in some cases precipices, but we don't know where. You and your reinsurer are tied together for your mutual success and safety. Make sure there's a rope on your waist and around your reinsurer's waist. If you stumble, you can depend upon your reinsurer to hold firm on that rope and keep you from falling. If you hit a precipice, you want your reinsurer there to be able to pull you back.

The reinsurer, on the other hand, is relying on you folks -- the direct writers -- more and more, today, to avoid the potholes and keep away from the cliffs. Each party, both the reinsurer and the direct writer, today has got to focus more on the strengths and the character of the people that he chooses to do the business with, the people that we're tying ourselves to. The reinsurers

recognize that we're relying to a greater extent on the direct writer. Your reputation, your track record, the professional approach to identifying the issues facing your business, your knowledge, understanding of your market and distribution, and your willingness to discuss and debate with your reinsurer, are all critically important -- perhaps more so today than ever before. Direct writers ought to be concerned about aspects of the reinsurer that maybe weren't an issue before, certainly financial strength, but perhaps more importantly business philosophy, risk selection support, capacity, ability to respond to unusual business situations, and a willingness to work with you (as opposed to just take business from you).

Reinsurers really do struggle to find reasons to support the various product structures that are proposed to us by prospective clients. Sometimes we simply cannot. Direct writers then have the option to change their product structure or to look elsewhere for the reinsurance support. And this is perhaps the critical point in the question of reinsurance support. The direct writer does have the option to change their selection criteria for their supply of reinsurance. I could find no one who could relate to me a situation where a company that was desiring to introduce a new term plan could not because of a lack of reinsurance support. However, many companies have stories (and I suspect there are those in this room who have gone through these situations) where, because of the response that they got from the reinsurers, they ended up changing their policy structure -- perhaps their pricing, perhaps their underwriting -- or were faced with having to accept terms that were less favorable than they had every reason to expect going into the reinsurance investigation. On the other hand, there are companies that have held the line, if you will, on the terms that they said they would accept. Rather than changing their policies or accepting the terms offered, they decided to change their reinsurers. I don't want to sound judgmental. Only time will tell the ultimate wisdom of the positions that the various companies are taking today.

There is no lack of reinsurance support for today's term products. But it is more critical than ever that you as the direct writer be clear on why you want reinsurance, what kind of reinsurance partner you need, and not focus simply on price support. If your reinsurers are balking, there's probably a reason why. To ignore that reason, to fail to consider the issues being presented, I would suggest maybe to accept a business risk that you ought to think twice about.

If your reinsurer does agree to sign on, it's probably going to be a decision based more on their reliance on you and on the rest of your company personnel than in their independent assessment of the success of the particular product. There's a very significant implication to this. If things should go wrong, the reinsurer is not simply going to question or alter their assessment of the business. They're going to evaluate the reasonableness of their degree of reliance on you, your company, and ultimately your ability to manage your business.

As we heard Norm talk about the changes in today's product development, it seemed pretty clear to me that our business is not going to slow down at all. We're going to continue to introduce product variations in an attempt to improve our experience as well as to provide a competitive advantage relative to the other products out there. We're going to be operating more and more based on our professional assessment of what we expect will be happening, as opposed to relying on what has happened in the past and in our assessment of what has happened in the past.

I want to leave you with the thought that you've got to be right often enough to make your reinsurers want to stay tied to you. We're in this business, like you, to make money. Most of the reinsurers, certainly the ones that take the time to come to Society meetings, are here because we want to be in this business. We want to be in this business for the long term. We are desperately looking for those partners that are interested in that long term perspective as well.

MR. PALACE: Just this little follow-up. I currently hold a ten-year level term policy with Transamerica and my intention at this point, without commitment, is to try to stay the course. Also, in our company, Transamerica, we are now very committed to getting away from the quick in and out, the one year reentry stuff. We've moved away from that with our new portfolio.

Finally our last speaker, Michael Shumrak, is going to talk to us on term products from a little different perspective. Some of you may perhaps wonder exactly what part this all plays and I am sure Mike will fill us in. But I would just like to make an observation that nontraditional marketing methods for products such as term insurance are becoming very popular, even among many organizations that hitherto have tended to be very supportive of their agency distribution system. And in many companies now, including many of the larger outfits (as I'm sure many of

you here representing those companies know), there is an attempt made to have those two very different distribution systems live together in . . . harmony may be too strong a word, but at least in some sort of mutual cooperation or a lack of antagonism.

MR. H. MICHAEL SHUMRAK: While I'm certainly going to get into what's going on now and what seems to be the trend in direct marketing of term insurance products, the early stages of the presentation, for those of you who really don't know much about this but want to learn a little bit, is to sort of overview the process, the economics, the types of products that are sold -- to sort of get everybody on a common ground.

One of the first things is that in direct marketing as a distribution system, there are three key elements of success. They are the list, which is pretty self-explanatory, the source of customers, the potential customers; the offer -- which is where the product comes in -- that's basically the product, the presentation of the product, the proposition to the customer; and then the copy which is the brochure, or the TV ad, or the media process that presents the offer, both in terms of its format and its script. Those percentages show that the list is the important starting point. Product and copy are helpful, but they won't pull it off by themselves. So again, the orientation should really be what sorts of customers you are working with or targeting.

In terms of the types of customers out there, in practice they divide into three categories: existing company customers, policyholders, generated through the agency system or possibly a property and casualty or mutual fund or other financial services types of activities; the endorsing third parties, largely banks, associations, strong affinity groups; and then finally going directly to get customers fresh, through either the renting of lists or the targeting of people through other sources, soliciting for leads on television, etc. In terms of pros and cons, the existing customers give your greatest opportunity in terms of profit margin. The problem is that even if you have a million policyholder names, there's a reasonable finiteness to that type of list in terms of direct marketing -- where we're in the business of trying to find successful marketing programs and roll them out to millions, not just a few hundred thousand or fifty thousand. So one of the advantages is profitability, both because of the affinity and the lack of having to pay for the list (having already developed it). Another disadvantage in multidistribution environments is the agent sensitivity of marketing -- even if it is a different product or a supplemental product. Third parties also have a high response and good profitability, but there's been a trend of over-saturation and an increasing greed, among the third parties, to the point where often the going rates that you'll pay these organizations for the list can often exceed the value-added in terms of marketing costs and perhaps better persistency.

The biggest area of growth is in the direct to the company area, otherwise known as broad market, where you are trying to expand your company's base. Strategically, this has a lot of attraction to companies because you're actually adding customers -- initially direct response customers, but also potential customers for your agency or other distribution systems. This has the highest risk and costs the most money. You have to rent the list, the response rates can be lower, but again you've got the greatest control. Profitability in a direct marketing business is directly related to the ability to control what you do with those customers once you sign them up for their first policy, in terms of being able to market them additional riders and policies at good profit margins.

There are several keys to a successful product offer. First it has to be simple to understand, which might mean that the ideal would be to have one-rate-fits-all, guaranteed issue, send your money in and you're issued and that's it. Secondly, and you'll see what I've unconventionally or nontraditionally put ahead of needs, is greed and impulse. Those of us, myself included, that started with a traditional distribution company experience have to realize that the perspective of this has to be more of a Procter and Gamble, Fidelity Funds type of thing, with a back-dropping that there have to be reasonable benefits and needs underlying the marketing and the positioning of the product offer. So the greed and impulse factor has to be recognized. We can't hide behind traditional intellectual, "Well, let's define their need and we'll be successful." There has to be that greed or impulse.

The perceived value should be at least equal to the economic value. It sounds simple but with so many offers out there -- a good example might be long term care -- we realize there's a great need for it but the limitations and the complexities and the cost of it gives the customer the impression that they're not getting good enough values for their money, or it isn't time to get it yet. This is as opposed to the accidental death product, which most of us don't think is such a great product

from a needs standpoint. To a customer though, when for $5 or $6 a month they would get a fairly high amount in case of an accident, to them that hits home more.

Reasonably priced. In direct marketing, there aren't the price wars, as in the agency term wars. It means more that there are reasonably proven budgets for certain product offers to certain clients. You've got to know those going in. You don't want to sell a $50 a month product to a $20 a month customer. The second dimension, which is the apples-to-apples, is that if you are just going to copy competitors, you really don't want to be charging significantly more for the same amount of coverage and the same product.

The scope of the offer is becoming more important. Scope means what other ancillary benefits (even if they don't cost much) you are putting in to make it seem like it covers more than just life insurance, or life insurance in just one situation. We'll talk about some product techniques for that later. Scope also means that you don't want to be selling $2,000 of term life -- who even needs that small an amount?

Let's talk about the ability to meet customer expectations. Direct response business issued through group trust often is on a nonguaranteed premium basis. That's fine, but you don't want to be in the situation where you've sold a fantastic rate and you're going back with rate increases or, in some of these groups, the groups could be cancelled. You don't want a reputation for failing to meet the promises you made in the promotion and attracting the customer.

Fast and efficient fulfillment is critically important. It's one of the toughest challenges in term life, where there is simplified underwriting, as opposed to a lot of the health products that could be guaranteed issue. Every day that passes, from the time the person puts their hand up and says, "I want the coverage," to the time they get on the books as a paying customer, the response rate drops off. Yet you've got to ask your questions, and possibly go through certain underwriting steps. So that's a real challenge in this particular product area.

A convenient payment mechanism is also important. While we all know that monthly direct bill has worse persistency, if you're going into the broad market (where people may not necessarily have a certain credit card or want to do EFT right off), you've got to have the flexibility to sign them up however they want.

Finally, there should be potential for add-on extension because, again, to acquire a customer or even get a third party client to respond, the profit margins aren't necessarily so huge. The opportunity in profits and premium growth is back-end offer. So you might have an offer on which the riders or upgrades or add-ons can be increased.

This is a sample current offer that's out there in the mail right now, a term life product offer. It's a step-rated premium approach, and you can see by looking at the example why that's used as opposed to other formats that we're more familiar with in the agency term products. Basically, in a reasonably small space you can lay out the people's ages; you give them four choices as to the size of coverage. The key aspect to direct marketers is that unless it's a very affluent market, it is very important to have several of those age/policy size cells to be, for example, $20 a month or less. If they're all $20, $30, $40 a month, even though that might be the appropriate rate from your pricing, they may respond but they won't eventually pay when they realize how much they've committed to. In this particular one, it's only issued up to age 60 and it renews to age 75.

Let's look at the product economics, not for that particular product (that's an example in the mail), but for a similar type of product. The way we look at it is that we start with the ECP, expected issued average premium, if you will. We're saying it's $200. The list fee, whether it's a third party or possibly broad market, is $60 per thousand names mailed. The mailing cost, which would include the printing and mailing of the brochures, and producing the mailing process, $300 per thousand. The gross response rate, which is the number of applicants -- not paid applicants, but people that put their hand up and say, "I'd like to apply for this" -- we're saying is 2.4 per thousand or a little bit less than a quarter of one percent. Taking all of those, then, like commission in the first-year, we're saying the marketing cost divided by the premium is 150% (that's the $300 plus the $60, divided by the $200 times the 50% converting of the 2.4 that responded).

Another way to look at it is to look at how much it cost you per paid application to produce this customer. To do so, again take the $360 total marketing cost and divide it by the 1.2 net response

(which is 50% times the 2.4). We'll further assume that the pricing annuity is 7.50 (that's just shorthand for the dollar a year at the pricing persistency, mortality, and interest assumption). The annuity is fairly high -- it's not that I'm assuming extremely low lapse rates, but again, it's an attained age product. Issue cost at $15 per paid application premium tax 2.5%; loss ratio 55%; maintenance cost, and by that I mean the direct maintenance cost for billing and administration and accounting and whatnot, $18; and then fixed and overhead expenses, and by that I mean the corporate allocated overhead, the direct response department and the people that are there no matter how much you produce, 5%. That leaves us with 7.5% pre-tax for profit margin. So that sets out the economics for a typical term life offer.

Another way of looking at it on a GAAP basis is to look at components of premiums. What we have is 55% of the premiums going to benefits; 20% for the marketing costs (taking the $300 which is really spent in the first-year and spreading it over the present value of premiums); the issue expenses are 1%; the maintenance costs, 9%; premium taxes, 2.5%; and then the fixed and overhead charge, 5%; all resulting in that 7.5% profit. If you had a marginal tax rate of 34%, that's about a 5% after-tax profit margin.

I'm presenting things more generally because I wouldn't want you to think that's exactly the set of assumptions you should use, (but it's a realistic example). For a few of the parameters, I'm setting out reasonable ranges for a lot of what's offered today. Average premium can be as low as $150, even lower, in terms of the overall average premium you're going to get from each customer. It can go all the way up to $300. It's a function of the age group, the size benefit offer, as well as if there are ancillary benefits, like return of premium.

The annuities, for the attained age type products anyway, can range from 6 to 8, again depending on the product design. Reasonable benefits, 50-60%. Again, a lot of this is done in a group trust environment so that technically, companies could even be below 50% unregulated. But most companies are offering benefits that realistically run in that range.

Issue costs can be as low as $20 per application, but they can go up to $40 or more. Again it's a combination of the nature of the market -- if you're going to deal with a lot of older people and offer them higher amounts -- and of how efficient the direct response operations are. Some companies, if they're just dovetailing it off of their agencies, can't meet those numbers even at $40. It's just that the nature of the process can't be transferred to a fast, efficient, low cost, direct response process. So the issue cost has a fairly wide range.

For maintenance costs the same thing is true. While these are very low compared to what you might see in an agency term environment, you really should be able to do it for $10-20 per year. This doesn't include the overhead, just the billing and the direct costs that vary with the activity of maintaining policies. Premium tax is 2.5%.

Fixed expenses and allocated overhead is 5%. To me, that's a reasonable number. How companies do varies a lot. Some may not even price to cover the corporate overhead. I've seen anything from marginal approaches to waiting to see what they get charged and then spreading it over the pricing the next year. But, again, it's an important number. Because if you're just dealing with a $200 or $300 a year sale, 5% of that only covers $10 or so. You'd better not be spending $5 million on the overhead and only have 50,000 policies underlying the business.

Profit margin is 7.5%. Again, it's not that competitive if you're targeting things right. You could price for a profit margin of 7-10% pre-tax, and be able to achieve it in all the markets that I've mentioned. Then you could conceptually say the marketing allowance is the balancing item.

In Table 1, I've tried to sensitize you because you can see those ranges in practice within any one given company and across companies. Depending on their strategy and their situation, the numbers can fluctuate tremendously. Under Scenario A -- they're selling very small amounts to very young people -- the average premium is $125. Persistency isn't so great, because they're young people; there are no money back elements of the premium;, it's pretty stripped down term insurance. So the annuity is 6; the loss ratio is 50%. The issue cost, because it's such a simple quick process is $15; maintenance is $10; the overhead and fixed expense is 5%; and there is the same 7.5% profit margin. What's left for marketing is the balancing item. It's 27% of premiums, which works out to 165% first-year. To a marketing practitioner, going into the broad market, that's a reasonable marketing allowance.

TABLE 1

Scenario	ECP	äx	LR%	Percent Premium Margin for F.E. & O.H.	Maintenance	MC/ECP%
A	$125	6	50%	12.5%	10.00%	165%
B	125	6	60	12.5	21.33	37
C	300	8	55	12.5	6.25	210
D	300	8	60	12.5	6.25	170

Scenario B is the same situation except that they have very uncompetitive issue and maintenance costs. Mainly because of that, and because their benefit to premium ratio is higher -- they're giving the customer a better deal -- they're only left with 6% of all premiums for marketing, which translates to 37% first-year allowance. That's not a great prospect, unless the response rate is astronomical. Scenarios C and D might be a money-back product, or a product on which, through certain size grading and spouse discounts or whatnot, they're getting $300 per person. If it's a money-back product, perhaps the persistency will be higher so I'm using annuity of 8. And in Scenario C I've got the loss ratio of 55%. Issue and maintenance of $30 and $15 are in the ballpark, in the middle of the range I showed up above. That all equates to 210%, which compared to an agent's commission sounds astronomical. If you add agency overhead and other expenses, though, it's probably not that high. But that's certainly a very good allowance for a direct marketer to go into a list and produce a lot of customers and meet those assumptions. Scenario D is the same sort of thing with a better deal for the customer, 60% benefits, and of course the difference goes to a lower marketing allowance. They still have a solid 170% to use. So you can see that the wide range doesn't mean that any one of those is bad. The only one that's really bad is the one with the 37%, in terms of the marketing allowance.

In Table 2, the mail and list fees are divided by the first-year collected premium produced, to give you sort of a first-year commission-type calculation. The MC is the marketing cost, the total marketing cost per thousand kits mailed. MAIL is the printing and postage cost per thousand items mailed. The $250-400 is a good range. I'm sure there are specialized stuffers that certain companies like an Allstate could do where it could be much lower; and conversely there could be a very select group where you know you'll get a higher response rate, but it's an upper income type of situation where you can spend $1,000 or more on a fancy kit. LIST can be anything from nothing (on your policyholders) to $100 or more per 1,000 names rented and mailed. Expected premiums (ECP), like we said, could be anything from $150 or so to $350. Gross response (GR) can be down to about 1 all the way up to 3 or more, typically it would be 1.5-2.5. Conversion (CONV) is the percentage of those people who apply that really do become paying customers. That can range from as low as 35%, which might be indicative of broad market where a lot of them may be on direct bill (may not know who you are, so they were sort of interested but when it came down to paying they fell off, and/or have a long delay in trying to turn these things around, if it takes forever to process the application), all the way up to 65-70% (in a situation where, maybe on a third party, all the people are more in their thirties and forties, the questions on the application look clean, and they use their credit card for billing).

TABLE 2

Elements of DRM Term Life Marketing Allowance

Formula	=	MC/ECP = (Mail + List)/ (ECP x GR x CONV), where
MC	=	Total marketing costs per 1,000 kits mailed
MAIL	=	Print and Postage = $250 - $400 per 1,000 mailed
LIST	=	0 to $100 per 1,000 names rented and mailed
ECP	=	$150 to $350 per kit responded issued and paid (RIP)
GR	=	Number of applications received per 1,000 mailed = 1.5 - 3.5
CONV	=	Percentage of applications that become issued and paid

Table 3 shows the same four scenarios in terms of all the economics, except what I'm doing is varying the mailing costs, the mailing lists fees and the conversion rates, to show how important

those are, and then solving for the response rate (GR). You can see that if you're not efficient with your mailing costs and your list fee negotiations, and if you aren't maximizing your conversion percentage, in Scenario A the gross response rate you need could be anything from 2-6.5%. In fact, in Scenario B it goes from 9-29%. So again, the response rate, once you've got your strategy laid out, is important (because the applications coming are what we all count), but what's really also key -- and has lots of leverage -- is average premiums, conversion, and keeping the mailing and production costs low.

TABLE 3

Scenario		Mail	List	Conv	Required GR/1,000
	Low	$250	25	65	2.05
A	High	400	75	35	6.58
	Low	$250	25	65	9.15
B	High	400	75	35	29.34
	Low	$250	25	65	0.67
C	High	400	75	35	2.15
	Low	$250	25	65	0.83
D	High	400	75	35	2.66

In terms of strategy and tactics, the problem is that we've got continuing lower response rates and lower average premiums, despite a still large untapped market for low cost death coverage. One of the causes is that unfortunately greed, not need, makes direct response sales and it's hard to do that with a life insurance offer -- they have to pay the ultimate price to collect on it. Market saturation -- there have been a lot of similar offers. Failure to price offers and not just products is another cause. Solutions are as follows: increase the response by product differentiation, that's probably the most important one; expand the scope to increase premium paid per application; increase conversion rates via segmentation; lower the marketing costs by managed marketing (you can get a better deal on your mailing production, and negotiate tougher on your list fees); issue and maintain one record per kit (so if you're offering the spouse on the same application, try to have the efficiency in unit costs recognized in practice); actively try to upgrade the coverage at issue ("you've been approved, how about another $10,000 above the $50,000?")

When we look at the sample rate brochure, some are one-rate-fits-all, but most of them are step-rated at attained age. There has been some success with level premium, but again it gets too complicated on the brochure -- you have to show every issue age. Policy size rate banding has been very successful in raising average premiums, so have spouse and family discounts. Guaranteed premium rates aren't that prevalent, although if you knew in your positioning of the product that was important it might be well worth taking the extra risk. Smoker/nonsmoker tends not to be used, although if you are in a special market, selling higher sizes (most of these offers are $10,000-100,000, but there are some direct marketers that go up to half a million dollars), then it becomes fairly important to cross section the people on a finer basis. Most of the offers are unisex because it's simple, and, I guess, socially more desirable these days.

Premium payment options are anything from send-no-money (makes it simple, but then you've got to worry if they'll pay); to cash-with-applications (but then in life insurance for a higher amount, you might worry about a conditional receipt problem perhaps); to deviated premiums (sort of creates a bonus type thing or a premium type thing -- for a dollar the first month sign up, and then your premiums go to the normal level after the second month); to credit card and EFT (certainly good for persistency, although it might minimize your chances to back-end market since you just automatically billed).

Benefit structure, as we've seen, is typically offering three or four benefit levels, usually a level death benefit term to 65 or 70. Cost of living increases have been tried. Educational assistance is a benefit where we might say, "We'll give you X% of your face amount for four years if one of you dies and one of your kids is college age and enrolled in school." Something that hasn't been tried, although it's done in the health products a lot, is to decrease the benefits after a certain age (so the rated premiums wouldn't go up so much).

Most of the business is done with simplified underwriting. A good thing to try is to get a dual application -- to get the spouse on the same application to increase the yield of average premium per responder. The application asks for personal information, typically focusing on circulatory, digestive, nervous and kidney health questions, drugs, alcohol, AIDS, other sexually transmitted diseases. It talks about dangerous sports activities and driving record. Some ask a question about activity at work. Many companies use the Medical Information Bureau (MIB). Some don't. You do get some hits, so it's debatable in the big picture whether it has to be standard practice. Attending physician's report -- most companies insist upon it and provide it. There are some companies that request it, but then make the customer pay if they want to follow through on the application.

Here are some of the trends we see to help meet the strategies I set out. Return of premium features: because it feeds the greed, "I get my money back if I don't need this," it helps the company -- you get a higher average premium; and if you're good at investing you have more of an asset in terms of product because of the reserves. Educational assistance benefits have been discussed. Low cost double indemnity -- sell them the offer I already showed you (choose your life amount and then for $1 a month you get double indemnity). That has a lot of appeal. Volume discounts by size or by family participation is another option. Some companies have tried incorporating living benefits into the offer. Others have these benefits increased by cost of living types of increases.

MR. PALACE: For anyone who's particularly interested in receiving information on Guideline XXX, Don Maves has put together a very nice package. If you leave us your business card, he will endeavor to see that you receive this information. We will now entertain questions.

MR. JOHN M. BRAGG: This is really a discussion rather than question. Our firm is in the mortality experience and AIDS experience field, as probably some of you in the room know. It's based on a large amount of data that is sent to us by many insurance companies. This short discussion has to do with XXX and with AIDS and with mortality standards.

There has been a tremendous improvement in mortality, and I'd like to just read three figures for you. These are the actual to expected ratios, based on 1965-1970 basis: 1975-1980 -- 76.4%, 1984 -- 64.6%, 1987 -- 60.0%. That last figure we just completed working on eight days ago in our 1989 report. You can see that there is a most astonishing improvement measured in that way. This does not mean that all the segments have improved uniformly, of course. What is the reason for the improvements? It's things like the quitting of smoking, the attention to the lifestyles and so on. This greatly overshadows the effect of AIDS. The 60% includes AIDS, and we believed at the time that 1987 was a bad AIDS year.

Now getting to XXX. The main problem with XXX, I think, is that the calculations are being done on 1980 CSO, which has a large redundancy in it for the very reasons I have just pointed out. If we had a proper up-to-date mortality standard to work XXX results on, it would no doubt be much more acceptable. Is that right, Don?

MR. MAVES: I would say the committee has not come up with any firm conclusions. But I've seen some detail figures that would indicate that maybe your direction is the right way to go.

MR. BRAGG: It's part of the picture anyway. Now getting to the AIDS question, Michael and Norm spoke very well indeed on the AIDS subject. We track AIDS in our data base, and yet we have higher percentages than the ACLI. They come up with 1-2%, don't they, Norm? We come up much higher than that, more like that 2.5-3%.

There are a couple of interesting things about it. We of course are looking at select duration, for business fairly recently issued. So maybe that's the reason why we're higher. Secondly, and this is very interesting and totally unknown, it is far higher on smokers than nonsmokers. (All of our data base is smoker or nonsmoker distinct and we can measure it). The fact that the percentages are much higher on smokers doesn't mean that smoking has anything to do with causing AIDS, I guess. But AIDS is a lifestyle thing, isn't it? As is smoking. So it's not surprising that it's much higher or worse on smokers. And the age range is tremendously wide. There's a general feeling that all AIDS claims are at age 35-40, but that isn't true. They go all the way from 0 into the 80s. It's an amazing range.

But no matter how you look at it, it does seem that the overall improvement that I mentioned first is far more important. You can imagine why I have a little bit of personal trouble with the AIDS projection, and especially with the suggestion that you need extra reserves and extra premiums. Maybe you do. I understand what they're doing, but typically they forget about the overall improvement that is taking place. I don't think it is proper to ignore that.

MR. LAWRENCE P. MOEWS: I would support what Jack said about AIDS -- the 1% or slightly over from the ACLI. I think it is vastly underestimated. We at Allstate have a percentage similar to what Jack mentioned. I suspect the claims we're seeing now with AIDS are beyond the contestable period, and I suspect a lot of companies when they get proof of death, assuming no fraud, are paying the claim. Or maybe the real underlying cause of death is coming in as something else. Does the panel have any comments on the idea that we may really be deceived by some of the AIDS numbers we are seeing, and that companies, once it's beyond the contestable period, really aren't investigating far enough to see what the real underlying cause of the death is?

MR. HILL: Let me just make a point. A couple of years ago I was with a company, or a group of companies, where we talked in some detail to all the claims managers at each one of the companies, to try to inject some uniformity in judging the claims. And they were not just relying on a specific cause saying AIDS. They had a series of causes that were kind of suspicious, that were likely to be AIDS related: certain types of pneumonia, certain types of cancer. So it seemed like they were doing a good job in trying to ascertain what the underlying cause was. You have to balance that against economics -- you can't investigate endlessly on a claim -- so maybe a few slipped by. But I'm hopeful that if the approach of that group was typical of the industry that they're doing a decent job; they're trying to ascertain what the underlying cause is.

MR. BRAGG: On the unreported AIDS claims situation which we've just been discussing, I think maybe the companies that are sending us data might be looking harder because they know what we're doing, but still it might be interesting. We look at the cells where the AIDS impact is supposed to be greatest, say in the ages 35-40 male range. We look at the actual to expected to see whether unusually high mortality ratios are sticking out at us. And we have a hard time finding that. You might find a 120% ratio sticking out at you from a fairly small data block, and maybe it's AIDS. But there isn't anything really dramatic sticking out at us.

MR. RICHARD E. BAYLES: We've been seeing some competitors' products which provide renewal term insurance up to as high as age 90. My concern would be the premium would be so prohibitive as to make the antiselection problem compounded. It's true that they have to buy it originally at a younger age, but I'm concerned about this market distorting the whole situation of term insurance.

MR. HILL: I would agree that renewal to age 90 sounds like it may be a little high. I'm just looking at one sample policy here that's convertible to about age 65 and renewable to 70. Are you inviting antiselection at that age, if someone wants to pay the premium? I suppose to some extent our focus in the industry has gotten more short term, which may be a good thing. So that if you're looking ten to 20 years down the road, there's a tendency not to look maybe 40 or 50 years down the road now with these policies to see what might happen.

MR. PALACE: Let me just add something to that. Essentially, graded premium whole life to age 100 takes it a little further than 90. And there's no question that there's a real potential for some antiselection -- we've actually seen some of that on our older official term blocks. But on the other hand, as the years go by, I suppose many actuaries have a tendency to see that it's sort of buried. It's hard to really segment the business that was written 30 years ago and say, "Here's some real antiselection." So we may be overlooking some, especially with inflation. I look at the size of the claims we're getting on term policies, 10, 20, 30 thousand. That was probably a lot of money 30 year ago. Now we're routinely writing policies a million and up, and you know that it's probably getting buried, but I think there's a real potential for antiselection. Those companies that do take the trouble to try to look at that on their historical blocks will find they may be setting themselves up for some real problems in the future.

MR. STANTON L. COLE: I'm with the ACLI, and I want to go back to Guideline XXX again. Don, I thought you did a real fine job of covering where we're at. I wanted to maybe punctuate one of the points you made, and that has to do with the extra lapse experience at the five year point or the ten year point, when all of a sudden that low premium doubles at five years, or

quadruples at ten years, or whatever. There's a built in lapse rate as you indicated, but there are some extra lapses that occur because of that dramatic premium increase. I guess my point, my request, is that if anybody has any experience about that kind of thing (I'm working with the industry task force with Don and the others), please let us have it because that's one of our stumbling blocks at this time. Do you want to add anything, Don?

MR. MAVES: Only that it would be nice if the experience lent itself to some easy rule of thumb. I'm not sure we can get that, though.