RECORD OF SOCIETY OF ACTUARIES
1991 VOL. 17 NO. 2

ACCELERATED BENEFITS

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MR. PHILIP A. VELAZQUEZ: This session is entitled "Accelerated Benefits" but it could just as easily have been called "Living Benefits Riders." You will probably hear both terms used by our panelists during this discussion.

Abe Gootzeit is a consulting actuary in the St. Louis office of Tillinghast/Towers Perrin. Abe has been very active in developing accelerated benefit plans for numerous clients. He is a frequent speaker on the subject and was recently part of the faculty for a seminar that was given in April during the New Orleans Spring Meeting. Abe will provide a description of the product features, pricing considerations and other actuarial issues.

Larry Patz is vice president and actuary at Concord General Life Insurance Company in Concord, New Hampshire. Larry's company has been selling a catastrophic illness rider for close to two years, and it has been well received by the market. Larry will speak to us about his company's success with the product.

Donna Claire recently formed her own consulting firm. Donna was chairperson of a task force for the National Association of Insurance Commissioners (NAIC) that looked into the actuarial aspects of accelerated benefits. She was also part of a regulator's working group on accelerated benefits. Donna will discuss regulatory issues.

I am an actuary with North American Reassurance in New York City. I will follow Donna and give you a few comments about what you can expect when you look for reinsurance for these benefits.

MR. ABRAHAM S. GOOTZEIT: I would like to talk about three topics and one is an overview of living benefit riders. The main part of my remarks though is going to be about product features. I would like to go over a number of the different products briefly and describe the workings of those product features and how they react with life insurance. Then I will have a few summary remarks that will try and integrate the remarks about the product features in a more coherent and concise pattern so you can discern some of the differences.

The first thing will be the overview of the living benefit rider marketplace. The basic design is quite simple for a living benefit rider. There is a monthly benefit or a single benefit depending upon the type of rider. The benefit is based on the policy size of the life insurance contract, the base policy. If you buy $100,000 of a life insurance death benefit and buy the living benefit rider on top of it, you automatically get what the company is offering for the living benefit rider amount. This means there is no individual selection of the living benefit rider, which is an underwriting consideration. All of these contracts have the same characteristic in common, and that is that these are advances of life insurance proceeds.

Why are companies doing these things? The most important reason is to sell more life insurance. I would say recently, over the last year or so, companies have adopted living benefit riders on a defensive posture; in other words, they believe that they need to have one of these things. They will have one sooner or later, so they might as well bite the bullet and do it now. Other reasons are simplicity, marketing advantage, and to have something that is a visible and desirable thing for their agents.

What about the financial risk profile of adopting one of these riders into your portfolio? Very importantly, the financial risk profile of the living benefit rider is much more controlled than the stand-alone health insurance counterpart. In other words, if you adopt a long-term care rider to life insurance, the financial risk profile of that rider is much more controlled than a stand-alone long-term care policy, so I don't think life companies need to be as afraid of these benefits as they might be if they were introducing a stand-alone product. At the moment, we can still get higher projected profit margins on the living benefit rider than we can on the base life insurance contract, and I think, that is a significant consideration. You can squeeze out a few cents of profit on this thing.

Next, I would like to indicate in Table 1 below those companies that entered the living benefit rider marketplace early, and some of those companies that entered it later on.

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

More recently we have seen larger companies with more significant market share entering the marketplace, and hence we have more widespread acceptability of the benefit.

Next, let's talk about marketability and how a company might tackle the marketing of one of these products. I think it reverts back to the needs-selling concept of life insurers. We kind of got away from that in the mid-1980s when we were selling replacement contracts, cannibalizing other companies' in-force, and maybe more realistically cannibalizing our own. These living benefit riders assist in the process of going back toward a needs-selling process. They are real benefits at an affordable price. A long-term care rider with a life insurance policy really makes a dynamite marketing package if it's done correctly, and very importantly, the differentiation makes direct comparisons of cash values more difficult. The 20th-year cash value of a contract loaded up with riders would not be directly comparable to Company XYZ, which is at the top of the market. There also is still the possibility of innovation. We have gone through a number of generations of living benefit riders and I am always surprised each year when one or two new ones come out.

If your company is thinking about the marketplace, what are some of the reasons to introduce? Most importantly you want to sell more life insurance and increase profits. There has been anecdotal evidence so far that there is improved persistency among life insurance policies that have a living benefit rider. There are a few other benefits. There may be enhanced prestige if you do something which is innovative and there may be an opportunity to do a better job of agent recruiting, by showing that you are more responsive to the marketplace. Later on in this session, we will be talking about the success story of one company in particular, but the early results are that there is about 20-25% penetration among those eligible policies that could have living benefit riders (these are the ones that you would have to apply for and pay an extra premium). That penetration has not varied much at all, but there is an enormous spread from company to company -- from as high as 55-60% to as low as, close to, or equal to absolute zero. Why are we seeing a wide spread in the penetration? The companies that are doing a good job of training, that have a good marketing plan and that make it an integral part of the way they do business are doing better as far as marketing these products and gaining success.

I want to turn my attention now to product features for a few of the living benefit riders that we have seen. My favorite, because it is most interesting to do as an actuary, is the long-term care rider. It is also the most complicated of the living benefit riders. The first contract that came out was back in 1987, and it had a monthly benefit equal to 2% of the first $150,000 or the amount specified in the contract, plus 0.5% of any excess over $150,000. However, in no case would the monthly benefit exceed the cost of the covered service. That was the first one, and I would say that virtually all contracts subsequent to that time have used the 2% as the driver. What does 2% mean if you purchase a $100,000 life insurance policy? Two percent of $100,000 is $2,000 per month, and that is very close to what the national cost for being confined in a nursing home is. The average cost nationwide is about $2,300. That varies from region to region, but $2,300 per month is about average and 2% of $100,000 does a good job of covering that expense. Most companies however will not use a flat 2%, just to guard themselves against overinsurance in cases when there are extremely large contracts. The reduced percentage

of 0.5% is one company's adaptation of handling the large size contracts. How long is the monthly benefit paid? It is paid until a specified portion of the death benefit is used up. That specified portion is also in the contract and it generally ranges from approximately 50-100%. There doesn't seem to be any problem with any state in offering a 100% benefit. A 2% monthly benefit which pays until all of the life insurance proceeds are gone will expire the proceeds in a 50-month benefit period or a little bit more than four years. This is a nice benefit period and it compares nicely with many long-term care policies.

We will need some triggering event that will pay out these benefits. The triggering event always includes confinement in a nursing home. Nursing homes are defined to include skilled nursing facilities, intermediate nursing facilities, custodial care, and sometimes hospice care. More recently, even in these long-term care riders, there has been a tendency to include other services provided outside the scope of the nursing home. Those types of services might be things like home health care, more infrequently would be adult day care, and very experimentally would be something like respite care. Home health care is a program that would pay for services provided to a person who has trouble with activities of daily living, as defined in the rider, but who doesn't want to or isn't severely impaired enough to go into a nursing home. There is no requirement that you have these alternative services, but if you do have them, you need to comply with the Model Long-Term Care Regulation which limits the way that you can prescribe alternate service benefits. So, that's a brief sketch of the long-term care rider. It is more complicated and has more moving parts than the other types of living benefit riders.

The next general category I would like to discuss is catastrophic illness riders. I am discussing the product types in some sort of sequential order. Generally speaking, long-term care riders came out first, followed almost immediately by catastrophic illness riders. The first company with that kind of benefit was Jackson National -- it came out with the plan in either late 1987 or early 1988. The catastrophic illness rider has a simpler design attached to it, which makes it desirable from a number of perspectives. First of all, it is a single benefit and not a monthly benefit. The single benefit is a percentage of the death benefit, typically 25%. Some companies have more than one offering, like a 10% benefit and a 30% benefit. There is usually a maximum total benefit that will be paid out. For example, even if there is a 25% benefit for the catastrophic illness, maybe only $350,000 would be paid out or advanced. Thus, if an insured has a $10 million contract, 25% of $10 million wouldn't be paid; the maximum which is specified contractually would be paid.

The list of the things that will trigger this payment is as follows:

- Heart attack
- Stroke
- Cancer
- Coronary artery surgery
- Renal failure
- Organ transplant
- Paraplegia
- Alzheimer's disease
- Blindness
- AIDS

The list of things on the left, or adaptations of that list, are found in every contract and one or more of the things on the right appear in some contracts, with the exception of AIDS. Earlier, we had discussions among the panelists about a

Massachusetts statute that was enacted in January. It is a slight modification of the Model Accelerated Benefit Regulation. The Massachusetts statute says that if you offer some of these things, you need to incorporate at least the following list, and one of the things on the list is AIDS. This is kind of scary, especially since AIDS isn't even defined; it just says AIDS. When is that triggered? It looks like the regulators are getting into things and muddying up the waters a bit. But, except for AIDS in Massachusetts, this is a simpler kind of concept to incorporate into your portfolio.

The next category of accelerated benefit rider to look at is a terminal illness rider that Capital Holding offered. Capital Holding's design is a little different than the more recent terminal illness benefits. It is a contractual benefit. There are premium charges which are made, either explicitly or implicitly. It can be attached to new and to in-force policies. The Capital Holding design would actually even attach to policies of other companies. For this benefit there is now an eligibility requirement that is talking about life expectancy. I am not sure how we know what life expectancy is, but it must be in at least three or four dozen contracts now. Some of the definitions are limited life expectancy of say six or 12 months. There is a definition or two which would say an 80% chance of death in the next year, and there are others as well. The qualifying event is being close to death. Once we hit the qualifying event, a single benefit is paid, around 25% or 50% of the total death benefit. Premiums on the remaining portion of the contract may be waived. There is a remaining death benefit which is available to the beneficiary. That remaining benefit is undiscounted. The full amount of the residual death benefit is payable.

The Capital Holding terminal illness benefit was one of the earlier designs and companies decided that they liked it, but they wanted to do it in a way that was administratively simpler. They came up with a similar kind of design but one that would advance the death benefits. A type of the benefit can be contractual such as the prior ones we've discussed, but they also can be extracontractual, like board resolutions or company practices. It does not have to be a contractual benefit -- typically there is more variation on this point for this benefit. Less than 100 cents on a dollar will be paid. Usually it is a fixed amount of 50 or 75%, possibly 25%. There also may be individual determination of the percentage; that is, there is individual information submitted to the company and, based upon the medical evidence submitted, the company will determine what the benefit percentage is. It doesn't necessarily have to be a fixed percentage. Once the benefit is advanced, the company will now accrue interest on the advance. There is a limit by some regulations about what that interest rate must be. There is a remaining death benefit to the beneficiary. However the remaining death benefit is no longer the full, unreduced amount, so those people who take the benefit are the ones who pay for the cost. This is a different concept. For the prior contracts that we talked about, everybody paid for the cost -- more like risk sharing in life insurance, something we are familiar with. Next is a comment on premiums. If we advance out this death benefit of 50 or 75%, we would also like to waive the premiums for a while so we don't require the person to pay premiums; however, the waived premiums that become due while the person is still alive and after the advance was paid, will be added to his lien and will start accruing interest as well. There are some companies that will start requiring premiums if, in their words, the insured miraculously lives past the end of the terminal illness time period, which might be 12 months. I am not sure if I would agree with miraculous. There are very few miracles that I believe in.

So that was the environment when Prudential came out with its living needs benefit. I will go over it briefly. This is touted very heavily as a no-cost contractual provision for new and in-force policies, and it is proposed that it will be operated in such a way that there will be no profit or loss to the company. The events that they will trigger the benefit on are two: one is terminal illness and the second is nursing home confinement. The terminal illness definition here is rigorous, a six-month life expectancy. The nursing home confinement requirement is also quite rigorous. The person has to be confined for six consecutive months, and be expected to remain there permanently; in other words, die in the nursing home. That is a very strong statement. The premium cost is none. The benefit is payable to the policyowner, not the insured, and is generally a lump sum, but it can be stretched out monthly over a period certain annuity. In the Prudential design, the individual does not know the amount of benefit that will be received upon occurrence of the triggering event. We have lots of words about how that individual offer will be tailored, basically today's value of tomorrow's death benefit, but we are not quite sure what the benefit will be until the actual offer comes back from the home office.

I have an example for a nursing home option. A $100,000 par whole life policy, issue age 65, was issued 10 years ago. Because of paid-up additions, the death benefit is now $152,000. The cash value is $76,000, exactly half of the death benefit. The example would indicate that if the person made the nursing home trigger, which is confinement in the nursing home for six months and expectation to live there until death, the lump sum offered by Prudential might be $118,000, a figure that is equal to all of the cash value and about half of the pure death benefit above the cash value. In other words, $76,000 of the lump sum would be available to the individual even without this benefit. What they're doing when they accept this offer is they are taking half of the pure death benefit right now and giving up the other half at death. Nobody will ever get that. That will revert to Prudential to offset its costs and its expectations of the future. There is no residual death benefit.

I have few summary remarks about the five product types discussed. I will start with the long-term care rider. The type of benefit is contractual. The payment mode is monthly. The benefit determination is contractual. There are premium charges, and the aggregate benefit which is payable upon advance and residually to the beneficiary is a full 100%. The same is true for the catastrophic illness rider, with one exception. The difference here is that the payment mode is single; in other words, we know everything, and the amount which is payable in total is 100%. The same is true for the terminal illness rider. This is the one where Capital Holding has a premium charge, not an accrual interest one. So, those three have stronger contractual guarantees. The advance offer benefit can be contractual. The benefit determination again can be contractual. There are no premium charges. The aggregate benefit is less than 100% of the death benefit. In other words, who pays for this thing? The people who use it. This is a significant difference in philosophy. Finally, the living needs benefit is the same. The aggregate benefit payable is less than 100%. The people who pay are the people who use it.

MR. LAWRENCE C. PATZ: I have been asked to discuss my company's experience in the payroll market regarding accelerated benefits. First I think we need a description of my company so you have a frame of reference. Concord General is a small wholly owned subsidiary of a regional property and casualty company in New

Hampshire. We have very limited resources. I am the entire actuarial department, and we have an inflexible, archaic data processing system, so that no matter what we try to do, we have to make it fit into the mold. Our primary market is payroll. Eighty percent of our sales come from this source, and of that, about 50% is what we facetiously call "guaranteed issue." The rest of the sales come from the property and casualty network. The term "guaranteed issue" is not entirely accurate because we do have some severe restrictions. The guaranteed issue privilege is permitted to be used only by certain agents with a proven track record.

Marketing in a small company is a very difficult thing to do. Market research usually means a five-minute phone call to our leading agent. While we recognize the need to be competitive, we have found that in the payroll market, product and service is more important than price. At the same time, we have to keep what we offer simple and relevant. A frequent question that we ask ourselves is, What can we do to gain an advantage? We very rarely have an answer to the question, but three years ago or so when we spotted articles about accelerated benefits, we felt we might give it a try. It did not take very long to realize that we needed some help, so we called on our friendly reinsurer to help us out and he did so quite willingly. Our primary motivation was to develop a product or rider that no one else had. While a number of companies are selling it, to our knowledge, at least in New England, no one is doing it in the payroll market. Because it was new, it took quite a while to decide on a benefit structure. We considered long-term care, but rejected it at least for a while because, in our market, with a low average age, we didn't think it would be particularly appealing. We considered the terminal illness type and rejected that for the same reason, so we ended up with the catastrophic event type. You can see our thought process. It was quick and easy, and we just eliminated the other possibilities and came down to the one. The rider that we developed is similar to Jackson National's, and it fit into the mold that Abe described with the five specific events of heart attack, stroke, cancer, coronary artery surgery and renal failure. We have a 25% benefit, and the policy is rewritten after a claim to 75% of its previous amount.

Rider development was difficult mostly due to the lack of data. We relied on our reinsurer for claim assumptions but did our own profit projections. Claim costs were increased somewhat after we came up with our underwriting requirements. The uncertainty of the whole thing and the lack of data prevailed on us to develop premiums of the current and guaranteed maximum type. The premiums were unisex, to be consistent with the rest of our portfolio, and we developed separate smoker and nonsmoker rates. We had a number of loud and lengthy discussions on what specific events to include. While we ended up with the five standard ones, we considered all the others including Alzheimer's disease, paraplegia, being trampled by a charging rhinoceros on the top of Mount Washington, and even AIDS. Interestingly, our medical director, a doctor with over forty years experience in medical underwriting, objected to including Alzheimer's at first, but after we had everything finished, he changed his mind and wanted to include it along with all the other conditions that have similar symptoms. Our final decision was based on a desire to keep the whole thing simple. We could always add additional events later.

The underwriting rules were particularly difficult to develop to everyone's satisfaction. The agents wanted guaranteed issue. The underwriters wanted a full nonmedical. I was concerned a little bit because the company has had good claim experience

overall, but in 1988 in particular, a disproportionate number of the claims that we did have were from cancer. On the group side of the company, 70% of all claims were cancer in 1988. We ended up with a simplified application with several general questions and with increased emphasis on family history and tobacco usage. Notice I say "tobacco usage" and not "cigarette smoking." We have no exclusion riders, no guaranteed issue and no substandard extras. It is standard or decline only. Remember, we are in the payroll market, and we have to keep it simple. The field force, especially those that have the guaranteed issue privilege, found this approach rather difficult to accept. We followed Abe's advice to have a lot of training and held a number of seminars. The agents soon came to see this product not only as a source of additional sales, but as a door opener to visiting employers, and all but a few agents eventually came to accept it.

Preparing the rider form itself was not difficult. Filing approvals proceeded surprisingly quickly considering it was a new concept in many states. Rhode Island wanted to be sure that there was no time limit for filing a claim and approved it as if it were a health rider. All the other states seemed to assume it was a life insurance benefit. We had a delay of some months while the data processing department got itself cranked up, and sales finally began in August 1989. For the first 12 months or so, 53% of all applications had the rider attached. For the last six months, however, the sales rate has slowed to about 25%. The reason for the sales reduction is not at all mysterious. Remember, we are in the payroll market, and each agent after prevailing upon an employer to let him in the door, tries to have an eyeball-to-eyeball interview with each employee, perhaps 15-20 minutes each. Before we had this rider, the agent could see three, perhaps four employees per hour. The rider requires a little extra explanation, and thus the agent will now see only two or three employees per hour. This means that the agent has reduced compensation. Actually, since most of our sales are of the money purchase type, for example $5 or $10 a week, many insureds spend the same amount of premium, so the agent has the result of making a rider sale with no increase in premium and no increase in compensation, and it has taken a longer time to do it. Perhaps half the applicants buy the same amount of insurance they would otherwise have at an increased premium. It is not surprising that the decrease in sales has resulted entirely among agents that have the guaranteed issue privilege. It is surprising it took a year for them to find out what this was all about. Hence, we are now reconsidering our underwriting requirements to see if we can make it a little easier for the agents. Regarding sales, the average size policy has decreased a little. The average age of the policies with the rider has increased a little, and there is a larger proportion of the total sales that are smokers. Older applicants, of course, are more likely to take the rider.

One marketing problem we had was the agents' desire to add the rider to existing policies. There is no particular problem with that if you can get adequate underwriting information, but the rider premium alone cannot cover the cost of underwriting and reissue. We allowed it in a few cases and decided to swallow the entire risk. We didn't want to have to confess to our reinsurer that we were doing that. Our claims experience has been remarkable. Through Monday, which was my last day in the office, we have not had one claim. While our death claims from policies without the rider from the same sales cohort rider has been normal, we haven't even had a death claim from those policies with a rider. Some of the reasons for this favorable experience might be good luck, brilliant actuarial work, low average age, and not very

many riders in force (about 3,000). Perhaps there is an insured who forgot that he bought the rider or who never really understood what he bought in the first place. I fully expect that the first claim we receive will be reported to us as a death claim, and we are prepared to make the beneficiary whole by adding some claim interest on the accelerated portion. The marketing people at Concord General have suggested only partially tongue in cheek that we use this fact in our sales literature. That makes me shudder. I can picture some aggressive agent telling an applicant that if he buys this rider he won't die.

Concord General has also developed a group term version of this. We filed it in only two states because we do an active group business in only two states. We have not made any sales, although there have been some quotes made and there has been some interest. In fact, the state of New Hampshire is considering it for their employees. The benefit is similar to the one we have in the life insurance policy, but of course, we don't have to contend with cash values, policy loans and that kind of adjustment. Both states, Maine and New Hampshire, approved it without question.

In conclusion, we were encouraged by the results. We think this kind of a benefit is here to stay even though some companies have had trouble getting if off the ground. I think that Concord General will continue in the market, and we will try to stay ahead if we can. We are very pleased with the results.

MS. DONNA R. CLAIRE: The concept of accelerating the death benefit for those who are terminally ill has been in the world market for more than a decade. South Africa has had this benefit for about 10 years. These benefits were sold in the United Kingdom (with mixed success) for several years, and Canadian companies entered the accelerated benefits market several years ago. There were some life insurance companies such as Jackson National and First Penn Pacific, who were among the first life insurance companies in the U.S. to design products for this market. However, probably the company which has spurred the industry, and definitely the regulators, is not an insurance company, and even after the regulations were passed, will not fall under them -- it is a company called Living Needs.

For those of you unfamiliar with this organization, let me give you a little background information. A small group of people recognized that there was a need for those terminally ill to have access to their life insurance benefits to pay for terminal illness and associated expenses. They formed a company to buy the life insurance benefits from these people at a cut rate (usually between 60-80% of the face amount). Living Needs then became the policyowner and collected the death proceeds from the issuing company when the person died. Living Needs is operational in 49 states (the one exception being Kentucky). It has bought the policies of about 150 people. It obviously filled a policyowner need, since no one was forced to give the policy to Living Needs. It also is obviously not an insurance company and is therefore not subject to insurance regulations.

Some insurance regulators are a bit upset at Living Needs. They could not regulate it and thus insure that the policyholder is getting a fair deal. Therefore, the regulators wanted the insurance companies to design benefits similar to Living Needs that would be considered insurance products. This was one instance where some of the

regulators were at the forefront of the industry, encouraging the introduction of a new product to benefit consumers.

The NAIC acted quickly on accelerated benefits. They formed a group in 1989, and the model law was passed at the December 1990 meeting. There was an industry advisory group, of which I was a member, to assist the working group of regulators.

There were several major issues that had to be addressed in the model law. One of the first concerns was whether the benefits were life or health insurance. Early in the process, it was determined to separate the benefits. Those that were like life insurance and paid noncontingent claims would be treated as life insurance; those that paid contingent claims, such as payment being made only as long as one was in a nursing home, were health insurance and would be regulated as such. The latter is regulated under the Long-Term Care Model Regulation. We are concentrating on the life benefits under the Accelerated Benefit Model in this discussion.

The regulators wanted to be sure that policyowners were aware of what they were buying. The model regulation contains a number of disclosures that must be given at the time of sale and must be in the policy. For example, it must be mentioned on the front page of the policy that the tax issues for this product are currently unclear and one should consult a tax attorney.

The regulators knew that accelerated benefits were a new field in the U.S. They therefore did not want to limit the design features. The model regulation therefore discusses the major types of designs current in the marketplace, more to suggest that these designs are allowable rather than to limit creativity.

There is a limit placed on the interest rate used when using the actuarial discount or interest accrual method for what Abe described as the terminal illness benefit or advance benefit. This limit is stated as the greater of the maximum current policy loan interest or a short-term Treasury bill rate, to handle those times where we are suffering interest rate inversions. This rule is, in part, due to the regulatory concerns about companies like Living Needs, who discount the face amount at a much higher rate and as a result pay a lower amount to the policyowner. However, as mentioned before, Living Needs would not be covered by this rule.

There are some general reserve guidelines outlined in the regulation. The more detailed guidelines for reserving for accelerated benefits are covered in the proposed Actuarial Guideline on Accelerated Benefits.

The actuarial guideline was written by a task force that I chaired under the American Academy of Actuaries at the request of the NAIC. For those of you who want a little more detail on the task force's thought process, a committee report is also available. This actuarial guideline is currently exposed for comments for possible adoption by the Life and Health Actuarial Task Force of the NAIC in June 1991.

The guideline does not give a required formula for additional reserves that should be held for accelerated benefits. This is because there is a variety of benefits in the marketplace, and there is no one formula that seemed applicable. Some benefits require no additional reserves. For example, if a benefit is paid using an actuarial

discounting method that produces equivalent benefits to the death benefit, no additional reserves should be required. The guideline does provide advice as to what should be considered when reviewing the reserves for these products. This includes:

1. The definition of accelerated benefits. Are benefits paid just to terminally ill people or are certain catastrophic diseases also covered? A rider covering catastrophic illnesses may be a richer plan and may require extra reserving.

2. Is the premium waived if someone elects to accelerate part of his benefit? If so, this is a richer benefit, and may require additional money to be set aside in the form of reserves.

3. The marketing method should be considered. For example, if the benefit is touted as one which an insured could qualify for with minimal proof, this may require additional reserves.

4. The underwriting procedures are important, as a policy which is not underwritten may have more substandard people who are more likely to qualify for the benefits, perhaps necessitating higher reserves.

5. The presence of a delay in eligibility for benefits can affect the expected payouts and the level of reserves required. For example, experience in Great Britain showed that there were a number of people who selected against the company at policy issue when the accelerated benefit provision was included. A delay in eligibility for the benefit of 30 days is allowed in the model regulation.

6. The maximum benefit allowed under the accelerated benefit option can affect the number of people who would choose this benefit, and also the potential for fraud in the claiming of benefits. This factor should also be considered when reviewing the reserve standard for these policies or riders.

7. If the inclusion of this benefit in the policy is optional, there would be more of a chance for antiselection than if all policies were covered, thereby increasing the potential need for extra reserves.

8. If guaranteed insurability options can be used to increase the amount that can be eligible for accelerated benefits, this can also increase the possibility that extra reserves would be required.

The overriding reserve requirement is that reserves should be sufficient in the aggregate. This does not mean additional reserves are required, even after accelerated benefit payments are made. For example, if a block of business was underwritten, and the accelerated benefit is allowed up to a maximum of 50% of the face amount, it is not necessarily true that additional future reserves would be needed just because a policyowner claimed the benefit. After all, the insured will die at the same time, and the reserves were considered sufficient when the insurance company did not know which insured was more likely to die; they should still be sufficient.

The actuarial accelerated benefit guideline also covers a number of other issues that should be considered when designing an accelerated benefit provision. For example, the accelerated benefit design should consider (1) the effect of an accelerated benefit provision if the policy were on an extended term or reduced paid-up insurance option; (2) the effect if the policyowner increased or decreased the face amount of the underlying policy; and (3) any limitation on either the amount of the payment or number of payouts allowed.

The guideline does not limit the policy designer as to what is covered or not covered. If the accelerated benefit provision does not specifically state how certain items such as those mentioned above are to be handled, the proposed actuarial guideline states that the most liberal interpretation for the policyowner should be made.

One fact must be emphasized for all those considering going into the accelerated benefit marketplace -- the tax treatment of these benefits, for both the policyowner and the insurance company, is currently unclear. According to the model regulation, this tax uncertainty must be clearly disclosed to the policyowner on the front page of the rider or policy.

There is some movement to clear up the tax treatment of at least some types of accelerated benefits. The Bradley bill, which was cosponsored by 30 senators, would treat terminal illness benefits as life insurance death benefits. A similar bill was introduced by Representative Kennelly in the House of Representatives. A bill which would cover other accelerated benefits was drafted by a group under the auspices of the American Council of Life Insurance (ACLI). Representative Gradison introduced a version of the ACLI bill, except that catastrophic illnesses are not covered under the Gradison bill. This bill defines accelerated benefits as qualified additional benefits under Section 7702 of the Internal Revenue Code. Although both bills claim to be revenue neutral, there is some concern as to whether there would be tax revenue lost, which is not a popular item in the current economic environment. Watchers on the Hill do not think that any of the bills will pass quickly, but they are giving odds that something will pass during this or the next session of Congress.

Until the Congress acts, there is exposure to adverse tax consequences from these policies under Section 7702. If accelerated benefits are considered a nonqualified additional benefit, any additional premiums paid do not increase the guideline premium limit for the contract. Any additional premiums would therefore reduce the amount of premiums that could otherwise be payable on the base contract and still have the contract qualify as life insurance. The Gradison/ACLI bill specifically states that these benefits are qualified, which has the effect of allowing any premiums paid to increase the guideline premium, and the payout amount would not be used to increase the endowment amount under Section 7702.

There are over 70 companies that are issuing accelerated benefits, which means that these companies have determined that the tax risk is manageable. Those companies that are considering entering the market should consult a tax attorney.

The ACLI has been actively involved in the drafting of the model regulation. Currently New York is the only state that will not allow any type of accelerated benefit, but there are bills pending to allow it here also. They will also help in any

state that will not approve accelerated benefits. As I mentioned before, the ACLI was actively involved in drafting proposed federal legislation on long-term care and accelerated benefits. It is actively working to try to have the tax issues resolved.

There are many state insurance departments that actively support the idea of accelerated benefits within certain guidelines. Several states have passed the model regulation or similar enabling legislation.

There are some concerns of insurance departments. One is that there are certain benefits that pay contingent payouts, such as long-term care benefits that are only paid while the insured is in a nursing home. These benefits are more like health insurance, and there are states that want to regulate it as such, establishing loss ratios and the like. Another concern, which was addressed in the model regulation, was that insurance companies may discount the death benefits at too high a rate. Those states that adopted the model regulation, and some other states, have limited the discount rate used in calculating the benefit. The discount rate does not apply to companies that pay for the accelerated benefit by charging an additional fee. The only guideline for the premium is that it be actuarially sound and equitable. There is at least one state that has not approved a policy form for an accelerated benefit because it was felt the premiums were excessive.

In addition, another thing to consider is that these benefits are new. There are no industry standards established. Therefore, the approval process can take longer for this benefit than with other policies. Certain states may require covering certain things, such as Massachusetts, which requires covering AIDS and organ transplant under a catastrophic illness rider.

In summary, there are still some open issues with these benefits, but a lot of people are working to have these issues resolved.

MR. VELAZQUEZ: During this portion of the panel discussion, I will discuss the reinsurance of living benefit riders. I will review the reinsurance of the long-term care and catastrophic illness riders first and then I will review the terminal illness design.

The mode for reinsuring the long-term care and catastrophic illness riders is typically yearly renewable term reinsurance. The reinsurance rates used may either be a fixed schedule or allowances to the cost of insurance charges in the rider may apply.

In setting retention, I have seen some companies keep an amount on the rider that is proportionate to the amount they retain on the basic life insurance benefit. I also have seen some companies keep a fixed amount. Under the latter, the payment of the accelerated benefit comes first from the ceding company's retention, and the reinsurer does not reimburse the ceding company until the payments under the rider have exceeded the retention amount that was fixed at issue of the contract. An example of how each type of retention would work for a catastrophic illness rider can be found in Table 2. For ease of illustration, I selected Option B in order to keep the net amount at risk fixed at the face amount of the life insurance contract.

My company's preference is the proportionate retention method. The benefit under the rider is simply an acceleration of a portion of the life insurance proceeds and we

feel we have an obligation to participate in our prorata share of that benefit. We also think it is easier to coordinate pricing with the ceding company. We would be incurring claims at the same time the ceding company is and thus could use the same incidence rates in setting the reinsurance costs.

TABLE 2

	At Issue:
$2,000,000	Face Amount, Universal Life, Option B
25%	Catastrophic Illness Benefit (Cap = $250,000)
$ 250,000	Ceding Company's Retention
$1,750,000	Reinsured Net Amount at Risk
	After Onset of Catastrophic Illness (proportionate retention):
$1,750,000	Face Amount
$ 218,750	Ceding Company's Retention
$1,531,250	Reinsured Net Amount at Risk
	After Onset of Catastrophic Illness (fixed retention):
$1,750,000	Face Amount
$ 0	Ceding Company's Retention
$1,750,000	Reinsured Net Amount at Risk

There would also be a better spread of risk for everyone since no one would be taking a disproportionate share of a new type of benefit whose pricing, quite frankly, may be based on "soft" data.

This doesn't mean that using a fixed retention is without any merits. In our example, the ceding company would pay the full $250,000 of catastrophic illness benefit under the fixed retention approach. In this case, the ceding company definitely simplified its reinsurance negotiations, since there was no need to have discussions about the pricing of the rider. Another item to consider is administration, especially with the long-term care rider, where a small percentage of the life insurance proceeds is advanced each month. Some companies are finding that with this type of benefit, it is preferable from an administrative viewpoint to pay the benefits initially from their retentions and thus alleviate the burden of reporting monthly reductions in ceded amounts.

I will next discuss the reinsurance implications of the other types of benefits that Abe discussed, such as the advance offer and the Prudential living needs benefit. Some companies have considered using the discount approach while others are finding the lien approach preferable. In evaluating which approach to consider, one should keep in mind the reinsurance implications. There should be special concern if the benefit is to be added to in-force business, which may be heavily reinsured already. If a company has dealt with numerous reinsurers in the past and those reinsurers are no longer active with that account, it is possible they will be less accommodating. Reinsurers may be limited in their flexibility by their own retrocession agreements. On a single large case, it is not unusual to have retrocession to several companies.

Of the two approaches, the lien is easiest to accommodate for reinsurers. Companies that use this approach will probably have an easier time when they present the program to reinsurers. We prefer it because it fits into our retrocession agreements. Many of our retrocessionaires require that we supply a copy of a death certificate before we are reimbursed for a retroceded death claim. Under the lien method, there is an opportunity for follow-up and securing of proof of death.

There are companies that wish to use the discount approach and allow the discount to be applied to the entire life insurance proceeds. Administratively, it may be preferable to eliminate the ongoing administration of the remaining portion of the policy. Also, this may be seen as an opportunity for a company to cut its losses; however, I would urge you to exercise caution here as you may be leaving yourselves open to adverse publicity and increased regulatory scrutiny if the assumptions used in the discount calculations are overly conservative.

For those companies that use the discount approach, we have offered to reimburse our proportionate share of the discounted accelerated benefits subject to the following conditions:

- Review of assumptions and formulas for computing the discounted benefits. This review would not be required on each and every claim, but we would want a general idea at the start of the program and would want to be informed of any changes.

- Less than the full benefit should be eligible for discounting. This would allow the opportunity for follow-up at the time of death.

- Review of accelerated benefit claim papers where we reinsure over 50% of the risk.

In conclusion, I want to emphasize that reinsurers want to be accommodating to these innovative benefits, but there are limitations to their flexibility. It is best to get these limitations discussed at the early phase of the product development process.

MR. JULE L. GEHRIG: In regard to the accelerated benefits, my company is not in this field yet. We have a large group client that wants a benefit added, and I can see only the fourth category, the terminal illness discounted benefit. Reinsurance would not be involved. Is any member of the panel aware of these types of benefits being attached to group insurance? Do you see any pitfalls?

MS. CLAIRE: There is at least one company in the group market; offhand I forget its name. The company had a representative on our task force. You can ask for additional premiums to cover any benefit. You have to clearly disclose them. When the insured applies for the benefit, you do have to make the appropriate disclosures, such as the tax consequences. We were trying to make it as simple as possible to allow the group market in also.

MR. GOOTZEIT: I think there are more like a dozen group companies. They are all term insurance, all experience rated, all terminal illness, all 25%. So it is getting some acceptability, and I think there is even standardization of product.

MR. STEVEN F. WRIGHT: I have a couple of comments, and then I have a question for Donna. My comments are going to come from a reinsurance slant. Abe, you stated that the financial risk profile is more controlled with a rider than with a stand-alone product for long-term care. I disagree with that. I think all you have to do is go to your head underwriter and ask him or her if they are comfortable with underwriters trained in underwriting life insurance now looking at this new health insurance risk. Also, I think the categories are a lot more blurred out there in the marketplace. A lot fall into terminal illness, whereas I think you might have been calling things living needs. I think they all usually lump under terminal illness.

Phil, my company does not have any retrocession concerns because what we are going to do is just keep it under our retention, and the amounts are usually capped at $250,000, and it is not a big deal.

Donna, you limit the interest rate for discounting, but you don't limit the discount period. Now, some companies that use the six-month life expectancy requirement may discount up to a year, and they can base that on sound actuarial principles such as antiselection, errors in doctors' estimates, etc. The question is, Why didn't you limit the discount period? I pose to companies that, if you're thinking about building in profits or extra margin by using a larger discount period, down the road states may also limit that, and that's another reason to cap the amount that you are going to offer for accelerated benefit.

MS. CLAIRE: The interest rate was limited specifically in reaction to companies like Living Needs, but you are right. In fact, some of the large companies in the terminal illness do exactly that. They will discount back for a year even though the so-called expected life expectancy is six months. I have a feeling that if the regulators see real abuses, they may come after those companies; however they also realize there are sound actuarial principles as to why one would not necessarily want to go with the doctor's so-called best estimate, considering the doctor in this case probably has the patient's best needs in mind, and if anything, might perhaps shorten the life expectancy and collect the most amount of money.

MR. VELAZQUEZ: As far as solving retrocession problems by capping, that is helpful if you keep a fixed retention. But where you quota share that won't help. Some of our clients have become upset when we mentioned setting caps at levels that were lower than those they had planned.

MR. GOOTZEIT: I agree with both of the comments you directed to me. I was thinking that all things being equal, it's certainly true that the long-term care rider is more risk controlled than the long-term care policy. I would submit to you though that the underwriting process for a long-term care rider doesn't need to be as refined as a long-term care policy because of the age differential that is typically found in the issues of these contracts. All we are trying to do is get better than population statistics for long-term care confinements. Long-term care riders for many companies have average ages in the 30s. Long-term care policies have average ages in the 70s. If a risk is standard for a base life insurance policy, at ages in the 30s, and you have already done a ton of underwriting on that individual, and you have culled out obviously ill individuals, I think you have an excellent chance of getting better than population statistics that the actuary assumed. So I agree with you, but I am not

sure that the underwriting process for doing a long-term care rider for average ages that we have seen in the marketplace requires a lot of rigor. I would welcome discussion on this point.

MR. IAN ARTHUR GLEW: My question relates to the second type of benefits that were discussed, the accelerated advance type benefits as opposed to the long-term care. Connecticut National is a brokerage company, and we see a fair amount of substandard business. Can the accelerated benefit be added to the impaired risk business, and if so, what additional considerations would apply?

MR. PATZ: I'm not sure if any of us wants to answer that question. In my situation, we don't want any substandard business in this because we are not getting very much information. I think we all would have trouble pricing a substandard situation. You might approach the matter with an exclusion rider.

MR. VELAZQUEZ: I have seen programs where they will accept substandard for the lower tables, perhaps not beyond Table 4. As far as data, typically the rates would be table adjustments to your standard cost of insurance. There is really not that much reliable data to price substandard business.

MR. GOOTZEIT: One of the problems with catastrophic illness on substandard is usually, or many times, the medical impairment is exactly the one you are covering in the catastrophic illness, which kind of accelerates the substandard rating on the rider. It tends to be a topic that many companies really don't want to address. At the moment, it doesn't appear to be a marketing disadvantage to many companies to take a simple approach.

MR. JOHN J. PALMER: I have two questions. One is a more general question. Are any of the panelists aware of significant incrementals in sales of life insurance on account of the presence of these kinds of riders on policies? The second one is more of a specific tax question. There are a lot of tax questions, as Donna mentioned, but the companies do have to report in some fashion or other when these benefits are paid. Are you aware of the particular approach companies are taking to reporting requirements?

MR. PATZ: I will answer the first question. We have not seen any increase in new business as the result of the rider, but at the same time, most of our business comes from New England which has been pretty hard hit by the recent recession. The fact that our sales had been level and not decreasing during this period of time might be due to the rider. Our agents tell us they also use the rider as a door opener to go see employers. However, I can't honestly say that the rider has increased sales.

MS. CLAIRE: There aren't that many companies that really have paid out that many benefits. There are some companies that really do view this as life insurance and will just provide that type of formula. There are others that are covering themselves and actually have admitted that there is a potential for it being treated as an early distribution, and do fill out that form.

MR. GOOTZEIT: The company that specified that it has gotten the most increase in life insurance sales because of this rider is First Penn Pacific, and I have heard Steve Lewis and Rich Klein from First Penn in panels similar to this quantify their estimate of how much additional business they have received. Theirs is the only company I have heard explicitly state such.

MR. ROBERT E. SWETT: I have two questions that are related to the rights of the beneficiary. Are any companies trying to get any kind of waiver or statement from the beneficiary or something to that effect? Are there any firm rulings about whether these benefits cause eligibility for Medicaid to go away?

MS. CLAIRE: Medicaid was an open issue when we were designing the model regulation; however we did get a letter from the person in charge of Medicaid and the letter stated that the presence of this benefit would not affect Medicaid eligibility. The payment of the benefit would be included in the amount of income, but the actual presence of the benefit does not affect eligibility. In terms of the beneficiaries, if it is an irrevocable beneficiary, companies are either saying you can't have the benefit or you must get a signed note from the irrevocable beneficiary. Another class of beneficiaries that people should consider is spouses in community property states because there is an open question as to whether or not the spouse automatically owns half the benefit. In such states you might need to get a waiver from them. For the general beneficiary, it is the same as any other benefit. The beneficiary has no rights until the person dies. They have the same right to this benefit as if the owner decided to cash out the policy, which is basically none.

MR. WARREN M. COHEN: Have any of the panel members seen extensive uses of these riders in the direct response market and what are some of the special considerations that would be necessary in that market?

MS. CLAIRE: While we were writing the model regulation, we did specifically consider the direct response market. The way the regulation is written you have to make clear disclosure at the time you are making the first pitch or when the person is going to purchase the benefit. So the presence of this benefit does not make it any harder in the direct response market; however, I am not particularly aware of any companies that are in that market right now.

MR. GOOTZEIT: The answer to your question might be no and simplicity.

MR. VELAZQUEZ: I have a question for Donna. Mention was made of the recent law in Massachusetts that requires AIDS as a covered condition for the catastrophic illness benefit. Do you see this requirement being introduced in other states?

MS. CLAIRE: I see a likelihood that certain states may add their favorite illnesses to the list required under catastrophic illnesses. Examples would be AIDS, organ transplant, and Alzheimer's. It depends on the special interest groups in the particular state. It should be a concern of anyone writing that type of benefit. Required illnesses are not part of the model regulation, but very few states are adopting the model regulation unchanged.