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ACCELERATED BENEFITS

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- Product trends
- State regulations
- Disclosure requirements
- Tax status

MS. ELEANOR S. HARTLEY: Nancy Baran is an attorney for Prudential. She's one of the developers of Prudential's accelerated benefit, which we call the Living Needs Benefit. Currently, she heads the traditional products division of Prudential's law department. She graduated from Seton Hall University School of Law and from Lafayette College. Nancy will talk about state regulations and disclosure.

MS. NANCY BARAN: I'd like to talk about the development of the NAIC model regulation. That regulation was drafted with a view toward two basic goals, one, consumer protection, and two, encouraging and facilitating the development of new products; recognizing that while this regulation was being drafted, new products were continually appearing and there was a need to allow that process to continue and the products to develop. Consumers need to be protected because, when a person makes application for an accelerated payment of a life insurance policy, it's usually at one of the most vulnerable periods in that person's life. The person is generally extremely ill and is in financially poor straits. To that end, there are a number of consumer protections that are incorporated in the model regulation, and in fact, in the regulations of most of the states that have adopted the model or something similar. There are minimum disclosure requirements set out in the regulation. There are limits on the kinds of impacts that an accelerated payment can have on the policy itself. There are standards for financing the cost of the benefit. And there are reserving and admitted asset treatment standards. However, although this is a fairly comprehensive regulation, it has left companies with the ability to develop varying kinds of qualifying events and varying kinds of funding mechanisms, resulting in different marketing strategies, and ultimately different products.

One of the questions that we struggled with early on, and that we found that the regulators struggled with as well, was the question of, is an accelerated benefit life insurance, or is it health insurance, or what is it anyway? The typical life insurance definitional statute in state law has two provisions that support at least the discount method. One is the special surrender value or special benefit in the event of the insured's total and permanent disability. You'll find that provision in the garden-variety definition of life insurance, in most state codes. The other provision, found often in

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the same place, is that life insurance also includes an optional mode of settlement of the proceeds. The lien approach may or may not come under one or both of those approaches, but it is permitted by the state's policy loan statutes in most cases, and it's expressly authorized by the model regulation. The additional premium approach is also permitted by the model regulation, and it's at least arguably a supplemental benefit, much as a disability waiver of premium would be.

The stated purpose of the model regulation in section one is to regulate the provisions of individual life insurance, for individual life, as it's marketed by agents, and in direct response sales, and for group life insurance. This presentation will focus mostly on face-to-face agent sales. The rules for group and direct response products are slightly different, mostly in the areas of the timing of the disclosure, at the time of solicitation. And most of those provisions require the same types of disclosure to be given, but to be given when the policy is delivered to the insured via the mail. Or, in the case of group coverage, the disclosures are required to be in the certificate.

There is a kind of competing product on the health insurance side, and it is long-term care. Accelerated benefits that are subject to the long-term-care model act and regulation are not regulated by the NAIC model accelerated benefits regulation. There's a specific exclusion for them. And that mirrors what is, in fact, a clear division of the universe into accelerated benefits that are life insurance, and products that are long-term care or health insurance products. The requirements for the health insurance product, long-term care, are very different from the life insurance requirements. There are different pricing requirements. There are different benefit requirements. There are different duration requirements. Improper marketing of an accelerated benefit that is life insurance will make it long-term-care insurance because of a provision in the definition in the model long-term-care act that says that any product that is marketed as long-term care is long-term care for the purpose of the regulation. What that means is that, if a product is mismarketed, it could fall into the trap of becoming health insurance. Many accelerated benefits would not qualify as health insurance, and therefore couldn't be offered at all, if that came to pass.

In this presentation, I'll try to deal a little bit with the various state wrinkles as they apply. The first one is Minnesota, which has the most unusual approach, I think, of all the 50 states in the marketing of accelerated benefits. First of all, all advertising material for accelerated benefits has to be approved by the commissioner for use in Minnesota before it can be used there. Second, accelerated benefit products can't be marketed to people over age 65. That's a flat prohibition in Minnesota, with only one exception, and that is, if it's a no-cost approach, and the offer is made to the policyholder one year or longer after the initial life policy is sold. The concern there, I believe, is that the products would be sold using scare tactics, or as a replacement for long-term care, or sold as long-term care.

Let's go into the guts of the definitions just a little bit. Section 2A of the regulation defines accelerated benefits as "payable to a policyowner or certificate holder," which you should try to remember is not necessarily the same person as the insured. So generally, the payment is made to the policyholder, regardless of whether or not the policyholder is, in fact, the insured. In anticipation of the insured's death, in specified circumstances that are either life-threatening or catastrophic conditions, they reduce the death benefit that would otherwise be payable, and the amount of the benefit is

fixed at the time that payment is accelerated. In other words, once a person chooses to accelerate, what they get is fixed. There can't, for example, be an annuitization of the benefit that's payable, as long as the insured lives. If the insured were to die early, there would be no more benefit. That's not going to qualify as an accelerated benefit. Obviously, the concern here is to avoid a windfall to the insurer. And, the benefit is payable on the occurrence of something called a "qualifying event," which is also defined. And that's a drastically limited or reduced life expectancy, as defined in the contract. Now, the model regulation says 24 months or less, for "drastically limited." A lot of states have changed that, for various reasons, some of those reasons being the uncertainty of life expectancy after 12 months. New York, Pennsylvania, and Connecticut, for example, all have 12 months or less, although I think Connecticut has a little bit of flexibility there.

Other qualifying events can be conditions requiring extraordinary medical intervention, without which the insured would die, or a condition that usually requires continuous confinement in a nursing home for the duration of the insured's life. And then there are specific dread disease elements that can be used as qualifying events if the insurer chooses. Serious coronary artery disease, stroke with permanent neurological deficit, end-stage renal failure, acquired immune deficiency syndrome (AIDS), and again here, in an effort to build in a lot of flexibility for insurers trying to develop new products, the commissioner has the discretion, in the model regulation and in most of the regulations that the states have enacted, to approve other kinds of qualifying events. There are a lot of state variations. For example, for reasons peculiar to New York state, there is no nursing home benefit available there. One might read the statute and conclude otherwise, but I don't think it would be approved. Michigan requires that a condition be either life threatening or of a catastrophic nature. Massachusetts ties back to the definition of life insurance, and requires that all of the qualifying events use the phrase "total and permanent disability." And so everything has to be a total and permanent disability, although it can also be one of these other things listed.

There are a number of requirements for the payment of accelerated benefits. The consent of the assignee or irrevocable beneficiary is required before an insurance company can make the payment. Although the regulation doesn't require that the company make the product available in those cases, if it's available, the consent is required. Companies are required to offer a lump-sum option, and they're not permitted to restrict the use of the proceeds. There are a number of other odd twists to state variations. For example, Connecticut imposes a 75% limit on the maximum amount of a policy that can be paid out. Michigan has a 25% test. Pennsylvania has a 25% test that's a little bit different. New York has an interesting timing requirement. Within five days of the request for an acceleration of benefits, the insurer must produce, to the policyholder, an illustration of the benefit and the impact that it will have on the cash value, the loans, and the death benefit. Then, for 14 days after that time, the insurer is prohibited from actually settling the policy. There's a sort of cooling-off period, if you will, during which time the policyholder can rescind the transaction. And then, after that 14 days has elapsed, the policyholder can receive the payment.

Because of the policyholder's and the insured's vulnerability at this time, there are fairly substantial disclosure requirements. In fact, I would say that, second only to the

systems changes, which introducing this kind of a benefit might require a company to make, the disclosure tests would be the most significant obstacle. The tax consequences have to be disclosed at three separate points. The disclosure, right now anyway, is that the benefits may be taxable, and that the policyholder or certificate holder should seek advice from a personal tax adviser. That disclosure has to be made at the time of solicitation or application, at the time that claim is paid, and it has to be contained on the first page, prominently displayed, of either the policy or the rider.

Going now to the other kinds of disclosure that have to be made at the time of solicitation, the benefit and the qualifying events have to be described, and the impact that taking such a benefit would have on cash value, accumulation account, the death benefit, premium, loans, and liens, all has to be disclosed. There has to be a signed acknowledgement provided to the company of receipt of that disclosure. That's another form that the agent has to carry around in his or her briefcase. If you are revising your application, it might be a good idea to include the signed acknowledgement portion in the application. It's a little bit less work for the agent. If there are premium or cost of insurance charges, those have to be disclosed as well. The disclosure has to include a generic numerical demonstration of the impact that those charges, and the benefit payment, would have on the same things, the cash value, the accumulation account, the death benefit, the premium, and the loans and liens.

New York has a very specific rule on this subject. Either an individual illustration is required, or a generic illustration that is precisely defined in the regulation. It's a very precise test, and not very negotiable.

In the model regulation, any administrative expenses, expenses of processing the claim, also have to be disclosed at the time of solicitation.

The disclosure at the time of claim has to be made to policyholders or certificate holders and to the irrevocable beneficiary showing that same impact on cash value, accumulation account, death benefit premium, loans, and liens, and explaining, again, the potential impact on taxable income and on the recipient's eligibility for governmental benefits, like Medicaid, Medicare, and Social Security. If a disclosure statement becomes outdated because of a subsequent acceleration, a new disclosure statement setting out those same pieces of information has to be provided, and a new schedule page has to be issued to a policyholder with each acceleration. In addition, if the policy is remaining in force because it's a partial acceleration, any continuing premium requirement has to be clearly explained at the time the claim is made.

Now, we'll go to the disclosures in the contract, or the rider itself. The title has to include the words *accelerated benefit.* The disclosure, again, is required that the proceeds may be taxable, and that the policyholder should seek tax advice. Some states require disclosure in the rider or contract about the potential impact on eligibility for state or governmental benefits. Connecticut requires disclosure on the face page that the death benefit is reduced by the receipt of accelerated benefits.

One thing that's required by the regulation is that, if there is an accidental death benefit on a policy that's accelerated, and if it's a partial acceleration such that the policy remains in force, the accidental death benefit has to continue in place,

unaffected by the acceleration. In other words, if there's a $50,000 policy with a $25,000 acceleration, but it also had a $50,000 accidental death benefit, post-acceleration, the policy would be $25,000 base, $50,000 accidental death benefit.

The regulation also sets out some actuarial standards. The premium has to be based on sound actuarial principles, with a proviso that for group contracts, experience rating is acceptable. For the present value calculation approach and the lien approach, specific interest rates are set out in the model regulation. The interest rate that's used for both approaches can be no greater than the greater of either the current 90-day Treasury bill rate, or the current maximum statutory adjustable policy loan interest rate. So, these numbers can be made lower in the contract, but not higher than permitted by the regulation. In addition, the lien approach requires disclosure of the interest rate that's used, either in the contract or in the actuarial memorandum accompanying the state filing, and for the portion of the policy loan that's taken in the lien approach, that would be similar in amount to the policy loan available under the contract. An interest rate no higher than the policy loan interest rate can be used. So if you have a contract out there with a 4% loan interest rate, and someone accelerates an amount that includes, say, something equivalent to a $20,000 loan against cash value, it's that 4% rate that has to be used for that portion of the lien, with a higher rate permissible for the balance.

The lien approach permits that the cash value is subject to the lien for the entire amount advanced, which means the amount that's accelerated, any future premium that may be payable under the policy, accrued interest on the loan, and any expense charges that were incurred at the time of claim. In the other approaches, no more than a pro-rata reduction in the death benefit and cash value is permitted. If there is an outstanding policy loan, and if cash value is reduced pro rata by acceleration, no more than the pro-rata portion of the existing loan can be required to be repaid out of the accelerated amount.

The actuarial memorandum contents are also regulated by this regulation. They require a description of the benefit and the risk to the insurance company of offering it, the expected cost, and the calculation of the statutory reserves. Companies are required to keep detailed descriptions of the procedures they use to administer the contract, and file for examination, if that's required. The reserves are required to be, in the aggregate, sufficient to cover policies both on which a claim has been made, and on which no claim has been made. But, in cases where the benefit is actuarially equivalent, then no additional reserves have to be put up. That would apply, I think, mostly to the discount approach. When the policy lien exceeds the policy's statutory reserve liability, the balance of the lien amount has to be carried as a nonadmitted asset. So, in effect, that's a charge to surplus. That about takes us through the model regulation.

MS. HARTLEY: Our next presenter is Erica Querfeld. She's from the Life Insurance Marketing and Research Association (LIMRA). She's manager of actuarial services there, and she's responsible for conducting intercompany persistency studies, compensation studies, and product surveys for LIMRA's member companies. She develops and conducts financial projections and models of life insurance operations, and provides information and consultation to member companies based on these studies and models.

MS. ERICA B. QUERFELD: I'm going to present results from a recent study on accelerated death benefits (ADB) conducted by LIMRA and the ACLI. It was conducted as of April 30, 1992. Since this benefit option was first introduced in the U.S. in 1987, the variety of products and number of companies marketing such a product have grown significantly. In 1992, about 60% of 202 respondents either marketed or planned to market an ADB product. Ninety-two companies, as of April 30, 1992, market 116 individual products. Twenty-four companies market 27 group products. Eight companies plan to introduce a product in 1993. I will first present results for individual ADB products, and then for group products.

ADB individual products were introduced in the U.S. in 1987. In Table 1 you can see about 90% of the companies introduced this product in 1989 or later. During the first four months of 1992, 18 products with this benefit were introduced.

TABLE 1
Introduction of Individual ADB Products

	Number of Products	Percent
Before 1988	1	1%
1988	9	8
1989	30	26
1990	33	28
1991	25	22
1992*	18	15
	116	100%

* As of April 30, 1992

Most products marketed specify only one type of triggering condition under which they will accelerate life insurance benefits. However, 15 companies in the study have products that pay for more than one event. One of three events usually triggers ADB payouts, terminal illness, long-term care, and dread disease. Over half of the products are activated by terminal illness. Thirty-seven percent pay ADB benefits for long-term care needs, while 22% are triggered by dread disease. Compared with older surveys, products that accelerate benefits in the event of terminal illness are becoming an increasingly large portion of the market, contrasted to long-term care or dread disease products.

Products that accelerate benefits for terminal illness typically require a statement, from one or more physicians, that death is likely to occur within a specified period of time, and this specified period of time is usually six months or one year. For dread disease products, conditions usually covered are heart attacks, strokes, life-threatening cancer, coronary artery bypass surgery, and renal failure. Some products, however, may cover major organ transplants, paralysis, and severe bodily injury. The long-term-care products cover home health care expenses in addition to confinement in a long-term-care facility.

Companies typically offer ADB in one or two forms. It's either a policy provision, or a rider attached to a policy. However, few ADB products are available as intrinsic

provisions of life insurance policies. Most companies are using the rider approach to add the benefit. However, one company in this study allowed either form.

How are ADB provisions added to new issues? As shown in Table 2, some companies automatically add ADB provisions to newly issued policies and do not require any action by the policyowner. However, almost 70% of the companies require the policyowner to request the benefit.

TABLE 2
Adding Individual ADB Provisions

	Number of Policies	Number of Riders	Total
Automatic	10	27	37
Request	3	70	73
Total	13	97	110

Companies market ADB products with most types of life insurance policies, with universal life being the most popular, followed by traditional whole life. Fifty-seven percent of the products are associated with only one policy type, which is universal life in half of the products. The remaining products may be attached to more than one type of policy. ADB options may be offered on newly issued policies only, or on both in-force and new issues. In this study, 60% of the ADB products are available to both new and existing policyholders, and 40% apply to new issues only.

How are companies charging for ADB? As shown in Table 3, companies typically charge in one of three ways. They either charge an additional premium or cost of insurance, discount the amount accelerated to reflect the interest lost to the early payment of the death benefit, or use the lien approach, where interest is charged on the amount accelerated. For all dread disease products, and most of the long-term care products, companies charge an additional premium or cost of insurance. For terminal illness products, companies tend to discount or use the lien approach. Over 50% of the products that have a combination of triggering conditions discount the amount accelerated. Some of the other practices in this study included not charging for the benefit, or charging administrative fees only.

TABLE 3
How Companies Charge for Individual ADB Products

Charges	Long-Term Care	Dread Disease	Terminal Illness	Multiple Triggers	Total
Additional premium	97%	100%	11%	13%	51%
Discount amount accelerated	–	–	32	54	20
Charge interest on amount accelerated	3	–	34	20	18
Other practices	–	–	23	13	11
	100%	100%	100%	100%	100%

The maximum amount of death benefit that companies will accelerate varies. Some products accelerate the entire face amount, while others limit the amount. Table 4 shows that about 60% of the products in this study limit the payout to 50% or less. Long-term-care products tend to either accelerate between 26-50% of the face amount, or they have no limit at all. For dread disease products, the maximum accelerated is usually less than 25% of the face amount. Nearly half of the terminal illness products accelerate between 26-50% of the face amount. In addition to these limits, many companies place an absolute limit on the dollar amount, which can be paid out as an accelerated benefit. Of products with these fixed-dollar limits, most of the limits are $200,000 or more.

TABLE 4
Individual ADB Payout Limitations

Limitations	Long-Term Care	Dread Disease	Terminal Illness	Total
No limit	44%	8%	14%	23%
Less than 25%	2	72	14	22
26-50%	40	16	49	39
51-95%	14	4	23	16
	100%	100%	100%	100%

How do companies distribute ADB? Companies typically offer two payout options, a one-time lump-sum payment, or periodic payments distributed over a specified period of time. Dread disease and terminal illness products are most likely to offer lump-sum payouts, while the long-term-care products usually offer periodic payments.

Because of the large size of the life insurance market, the overall potential for living benefits is also quite large. However, public awareness has been limited, despite the media attention surrounding such products. About one-third of the public is aware of these new life insurance policies. Eighty-one companies in this study supplied sales data, and there are over 2.3 million policies in force with ADB provisions, or riders, as of April 1993. This is more than double the number of policies in force a year earlier. However, several companies did extend ADB provisions to all of their in-force and newly issued policies.

What has the claim experience been of ADB products? Since the benefit is relatively new to the market, the reported claims remain low. There have been 612 payouts as of April 30, 1992, which amounts to 0.03% of the total in force. Over half of the payments have been made for products with more than one triggering condition.

Fifteen percent of the products have changed since their introduction. For example, some companies added another payment option or added another triggering condition. Some companies reduced or increased the maximum issue age. And some companies changed the method for charging for the benefit. And some of the long-term-care products changed qualification levels to include activities of daily living.

Now I'll present results for the group ADB products. As shown in Table 5, 24 companies in this study reported on 27 group products. The first product was

introduced in 1989, and three-quarters of the products were introduced between 1991 and 1992. The group ADB products are similar to individual products on the market. Over 90% cover terminal illness, 25% apply to long-term care, and 20% to dread disease. Nine companies pay for more than one condition. Group accelerated benefits are available as riders in 16 products, as policy provisions in 8, and as either a policy provision or a rider in 3 of the products. Almost 75% of ADB products are automatically added to group policies. The remaining must be requested by the insured.

TABLE 5
Introduction of Group ADB Products

	Number of Products	Percent
1989	1	4%
1990	6	22
1991	14	52
1992*	6	22
	27	100%

* As of April 30, 1992

Group ADB products are available with most types of group life products. Group term is the most common. Depending upon the company, group ADB are available to either newly issued policies only, or to both policies already in force and new issues. Eighteen of the 27 group products extend ADBs to both new and existing products.

As with individual products, companies typically use one of the three methods to charge for ADB. Almost 50% charge an additional premium. Four companies did report alternative methods, such as not charging for the benefit, or charging administrative fees.

Some companies set limits on the amount of death benefit they will accelerate. Almost 60% of the products limit payout to 50% or less. Nearly three-quarters of the group ADB products are paid out in lump sums. The remaining products allow choice-of-payment option, periodic payment, or one lump-sum payment.

Companies reported sales data for 20-27 products. There were about 380,000 certificate holders as of April 30, 1992. Eighty policyholders received ADB as of the first four months of 1992, which amounts to 0.02% of the in-force policies. Most of the payouts covered terminal illness.

How does 1993 look for new products? This year, eight companies plan to introduce nine products. Eight are individual, where six will accelerate for terminal illness only, and two will pay benefits for both terminal illness and long-term care. The one group product is triggered by terminal illness only. All of the ADBs to be introduced will be riders. Half of the individual riders are available to newly issued policies only. The remaining half, along with the group rider, are available to both in-force and newly issued policies. Most of these new products charge the policyholder for ADB using a

lien approach. All of the new products pay the insured in one lump-sum payment. Two individual products do have a second option. One will make periodic payments, and the other will work out a mutually agreeable arrangement with the insured.

MS. HARTLEY: To talk about the tax status of accelerated benefits, we have Stan Cole. Stan is a graduate of Amherst College. He joined the ACLI in 1988, and has been involved with both state and federal life insurance issues at the ACLI. His current responsibilities involve providing actuarial support to the federal tax department, specifically with respect to Sections 7702 and 848 of the Internal Revenue Code (IRC). Stan received his actuarial training while he was with Prudential, and he's spent time in both Prudential's Newark and Los Angeles offices. He also spent several years with Beneficial Standard Life Insurance Company in Los Angeles, prior to relocating to Washington. His experience has been primarily in the area of individual life insurance, and currently he is President of the Middle Atlantic Actuarial Club.

MR. STANTON L. COLE: I guess you can tell that I'm older than everybody else on the panel, because there were extra words there.

The issuance in December 1992 proposed regulations covering the taxation of ADB was the culmination of serious efforts on the part of the industry over the last couple of years to have the tax status of these new benefits clarified. In fact, for a while during 1992, the legislative approach looked to be the route by which at least some degree of certainty was going to be provided. Alas, however, the pertinent language, which had been proposed by Senator Bradley, did not survive the House-Senate Conference Committee, but in the end, this deletion made no difference because you'll recall that President Bush ultimately vetoed the tax bill on the day after he was defeated, last November 1992. Therefore, it was with a great deal of satisfaction that most of the industry greeted the proposed regulations. I say most of the industry because the lien approach to providing ADBs is not blessed by the proposed regulations. Those companies using this approach, and there are many, as Erica pointed out, could naturally conclude that the regulations leave something to be desired. But I'll have more on liens a bit later. As indicated in the preamble to the proposed regulations, their stated purpose is, and I quote, to "provide insurers with the standards needed to design and market insurance contracts that provide both death benefits and morbidity benefits without subjecting policyholders to taxation on the inside buildup of life insurance contracts." Such benefits are identified as, first, ADB payable in the event of the insured's terminal illness, and second, accident and health benefits payable for morbidity risks which include certain dread diseases and the need for long-term care in a nursing home. In these remarks, I will first review the proposed regulations, and provide an overview of the extensive comments on them, which the ACLI submitted to the Treasury Department and the Internal Revenue Service (IRS) in March 1993.

According to the proposed regulations, an ADB is a qualified ADB only if it satisfies the following three conditions. The first condition is the ADB is payable only if the insured meets the definition of *terminal illness*, and then terminal illness is further defined in the proposed regulations. An individual is considered to be terminally ill if the insurer determines that he or she has an illness or a physical condition that, notwithstanding appropriate medical care, is reasonably expected to result in death within 12 months from the date of payment of the ADB. The second condition is the

amount of the accelerated benefit must be equal to or greater than the present value of the reduction in death benefit otherwise payable in the event of the death of the insured. And the third condition is the ratio of the cash surrender value of the contract immediately after payment of the accelerated benefit to the cash surrender value of the contract immediately before such payment must be equal to or greater than the ratio of the death benefit immediately after the payment of the accelerated benefit to the death benefit immediately before the payment.

Qualified ADB's, which are received on or after the date when final regulations are issued, will receive income-tax-free treatment under Section 101(a) of the Code. In addition, contracts providing this benefit will continue to meet the definition of life insurance under Section 7702.

With respect to morbidity risk benefits, one of the objectives of the proposed regulations is to adopt an approach that assumes that a life insurance contract and an A&H contract, which could be sold separately, should be allowed to be sold together without endangering the qualification of the contract as a life insurance contract under 7702. To preserve qualification of the contract as a life insurance contract, the proposed regulations exclude amounts payable as morbidity benefits from cash value if the following conditions are satisfied. First, the benefits must be paid solely upon the occurrence of a morbidity risk, which is not defined. Second, the charges for the benefits must be separately stated and currently imposed by the insurer. And the third condition is that the charges are not included in premiums taken into account in the determination of the investment in the contract under Section 72 of the code, and are also not taken into account in the determination of the premiums paid under Section 7702(f)(1). Please note, however, that the proposed regulations say nothing about the tax treatment of such accident and health benefits when they're received. And this omission is undoubtedly by design.

The proposed regulations define "cash value" generally as the greater of the maximum amount payable under the contract, without regard to any surrender charge or policy loan, and the maximum amount that the policyholder can borrow under the contract. That definition is slightly different from the old definition of cash value in the legislative history, and critically different. This definition of cash value is further defined to exclude certain identifiable amounts, such as death benefits, fortunately, qualified additional benefits, and any morbidity risk benefits. What is critical in all of this is that the death benefits, which are excluded from cash value, are defined to include qualified ADB, thus enabling the payment of such benefits not to violate either the cash value or corridor test of Section 7702.

The following dating considerations need to be kept in mind. First, with regard to the effective date as it would apply under 7702, the proposed regulations would be effective generally for contracts issued on and after July 1, 1993. Second, for contracts with terminal illness or morbidity risk benefits that are in force prior to July 1, in other words, contracts already in force, the benefits, even under the lien approach, are not considered to be cash value. And thus, any such contract would not violate Section 7702. Third, such in-force contracts, however, would presumably be required to adhere to the three qualified ADB conditions previously mentioned to receive favorable 101(a) treatment after July 1. And last, the addition of either a qualified ADB or a morbidity benefit to existing contracts will not change the effective

date of such a contract. With respect to Section 101(a), as written, the proposed regulations do not provide for any safe harbor treatment for any qualified ADB or terminal illness benefit received prior to the day of the final regulations.

Now I'm getting into the second half of my remarks. Although the membership of the ACLI is generally supportive of these proposed regulations, we did file rather extensive comments with the IRS and Treasury, in which we pointed out several serious shortcomings. In addition, we testified at a public hearing in March 1993, and we have since met with government officials on two occasions to exchange viewpoints and to answer questions that they had about our written comments.

Our written submission covered what we consider to be five issues of major importance to the industry, as well as several others of lesser significance.

Clearly, the major issue to those companies that use the lien approach is the absence of any safe harbor for the lien approach to paying terminal illness benefits. The submission points out that this approach is essentially similar to the benefit reduction approach which was adopted, that it is used by a large segment of the industry, that it's fair to both policyholders and insurers alike, and that unnecessary disruption would be caused throughout the industry, should it not ultimately be included in the final regulations. It's hard to identify what the government officials' concern with the lien approach is, although presumably the specter of the need for less rigorous underwriting is involved in their concern, since they might contend that, after advancing the death benefit, a company merely has to charge interest against the ultimate claim in order to be made whole. In this scenario, the vision of excessive cash being paid out in violation of 7702 is the likely area of concern. In any event, one of the two meetings with the government was specifically on the subject of liens, and it appears that they'd be satisfied with a lien approach which is "economically equivalent" to the benefit reduction approach. This probably means the lien approach would require that any ADB payments be taken from the policy's cash value and net amount at risk in proportionate amounts, and that the benefit payment be discounted for one year at whatever interest rate will be permitted in the final regulations. We'll have to wait and see.

A second major issue deals with the definition of cash value, a term which is specifically defined in the proposed regulations. The definition is a very broad one, and as I mentioned earlier, provides that the cash value is the greater of the maximum amount payable under the contract, without regard to any surrender charge or policy loan, or the maximum amount that can be borrowed under the contract. This definition is so broad that it even covers the value of contract benefits. The drafters recognized this by providing certain exclusions, including the amount of any death benefit or qualified additional benefit under the contract. Of critical importance is the fact that qualified ADBs are treated as death benefits and are thus excluded from cash value. Similarly, morbidity benefits are also excluded. The ACLI, in its comments, provided several additional exclusions that are felt to be necessary to make the sweeping definition of cash value workable. Included among these additional exclusions are the following: the amount of any policyholder dividends left on deposit with a company under the contract; the amount of any premiums paid in advance; the amount of any premium deposit fund, or any similar amount on which any interest is credited, and is currently taxable to the policyholder; any annual dividend payable under the contract or pro-rata

portion of such dividend payable on contract termination; and any pro-rata portion of a periodic premium on contract termination, or any pro-rata refund of charges assessed in advance under the contract. And there were a couple of other individual exclusions that we requested.

Another issue meriting comments dealt with a clarification of several aspects of morbidity event benefits provided for in the regulations. In particular, the ACLI requested that final regulations provide first, that the premium or charge, if any, attributable to the morbidity event be determined by comparing a life insurance contract with such morbidity benefit with a similar contract without such benefit. The second condition was that such premiums or charges, if any, should be excluded from the life contract's investment in the contract, and should be considered currently imposed at such time as they are no longer reflected in the contract's cash value, investment in the contract, and premiums paid. And the third request is that premiums or charges for morbidity event benefits should be considered separately stated if they are set forth in a written communication to the policyholder.

A fourth major area of comment dealt with how the payment of terminal illness or morbidity benefits should affect the calculation of a contract's guideline single and guideline level premiums. Normally, benefit reductions activate adjustments to these values under Section 7702(f)(7) by means of what is known in my world as the attained age decrement rule. The industry argued, however, that this rule, which disproportionately reduces guideline limits applicable to the benefit amounts left in a contract, and may even force out amounts from the contract, is not appropriate under ADB scenarios. Rather, what is appropriate is a simple reduction on a proportionate basis of all of the values associated with a specific contract, such values as death benefits, cash values, guideline premiums, and premiums paid to date. The attained age decrement rule, which is in the legislative history, rather than a proportional rule, was incorporated in that history in order to avoid the situation where a benefit reduction, followed immediately by a benefit increase of like amount, would serve to produce adjusted guideline premium limits, which were greater than had existed without those two changes in amounts, downward and then upward. In terminal illness or morbidity risk situations, however, the policyholder does not normally willingly seek the payment of early death benefits, and would not be expected to satisfy underwriting requirements for future benefit increases. Most of them don't get better. Thus, for the reasons identified, as well as for simplicity, it would seem that a proportional rule, under these regulations, makes eminent sense, and that such a rule will, we hope, be adopted.

In its written comments, the ACLI requested that a reasonable transition period be provided, after the final regulations have been issued, so that companies will have time to modify their contracts or riders and to secure the necessary state approvals. A period of two years from date of issuance of the final regulations was requested, during which period ADB could be included in contracts without the value of such benefits being considered as cash value, and thus disqualifying the contract.

More recently, we filed a supplemental submission requesting that the June 30 effective date of the proposed regulations be changed, so as to coincide with the date when final regulations are issued.

The proposed regulations provide that the Section 101(a) exclusion for qualified ADBs would be effective only for amounts received after the date of the final regulations. This approach would seem to disadvantage terminal illness payments made prior to such date. In recognition thereof, the submission recommends that 101(a) exclusion treatment be provided for terminal illness payments or advances made prior to the end of any transition period, which is we hope two years from the date of final regulations, as we requested. In view of the relatively few terminal illness claims which have occurred to date, and which may be expected to occur in the near future, there would seem to be no tax policy reason why this request should not be accommodated.

The ACLI provided comments on several other issues, as well. While these tend to be less general in nature, they can nonetheless have important consequences. There were at least four such issues: first, the need to modify the discount rule; second, the question of how to handle the calculation of relatively small adjustments to the ADB; third, the need for the final regulations to permit Section 101(f) contracts, those are old universal life contracts, to pay ADB that qualify under the regulations; and fourth, the need for the final regulations to clarify that they apply to term life insurance, including group term, and to contracts issued prior to the effective date of Section 101(f). And I'll just say a few words about each of those.

With respect to the discount rate used in determining the minimum amount to be paid under a qualified ADB, the regulations provide for such rate to be the greater of the applicable federal rate (AFR), or the interest rate that applies to loans under the contract. The problem with this rule is that companies currently must adhere to the interest rates mandated by the NAIC model regulation. And that's, as Nancy pointed out, the greater of the current maximum adjustable policy loan interest rate permitted under state law, or the 90-day Treasury bill rate. The ACLI has recommended that the final regulations simply conform to the NAIC model regulation. This recommendation would seem to be sensible for several reasons. For one thing, the NAIC rate is much more current than is the AFR. In addition, companies would not have to incorporate a new set of discount factors into their computer systems. And last, given that the NAIC rate is required for statutory compliance purposes, it seems unlikely that the AFR would, in practice, be used in any event.

The next issue deals with how to take into consideration the calculation of relatively small amounts when calculating the amount of the ADB. Such small amounts include unpaid premiums, contract charges, administrative expense charges, future dividends, and unearned premiums. And we also included contract loans in there, and we have to acknowledge that they don't necessarily constitute relatively small amounts. But the idea here is to place the amount of the ADB to be paid on an apples-to-apples basis with a standard defined by the regulation, and which we believe to be the present value of the reduction in the death benefit otherwise payable in the event of death. In this way, it would be expected that inadvertent disqualifications would be avoided.

The proposed regulations do not address the treatment of Section 101(f), flexible premium life insurance contracts. They also do not confirm that life insurance contracts issued prior to the enactment of Section 101(f) can pay living benefits that qualify under the regulations, although the industry assumes this to be the case. We

believe that all life insurance contracts that provide living benefits should be able to qualify under the proposed regulations. In this regard, we suggested language for treatment of Section 101(f) contracts. In addition, we recommended that the preamble to the regulations clarify that contracts issued prior to the effective date of Section 101(f) can pay qualified ADBs and morbidity risk benefits.

Another issue of concern deals with the treatment of term life contracts. The proposed regulations talk exclusively of cash value in life insurance contracts. We believe that the final regulations should clarify that they are equally applicable to term contracts, including group term contracts, which provide qualified ADBs or morbidity benefits, even though such contracts have no cash value. Last, with respect to Section 848 deferred acquisition cost (DAC) regulations, the industry has taken the position that the addition of living benefits products to life insurance contracts does not constitute a taxable event under the recently issued final regulations for Section 848. And that, as you know, covers the capitalization and amortization of certain policy acquisition expenses. We believe that the addition of living benefits should not be considered an internal exchange resulting in a fundamentally different contract, as required by the DAC regulations.

MS. KATHERINE G. EDWARDS: Eleanor, I wanted to say, you had a great panel, and it was very impressive. I have three questions. First, when the terminal illness benefit is paid out for, say, a defined death within six months, have there been any studies to show what the mortality experience really is? Do the people die within that six-month period? Second, has any tracking been done as to where the money is being spent? Are the benefits being used for medical bills, or are people taking that dream cruise to the Caribbean? And last, have you encountered any cases of fraud, where the life insurance company physician disagrees with the personal physician, that mortality is not impending?

MS. HARTLEY: I can answer the first part of that. As far as when people die, under the Prudential plan, we've done some studies, and we've found that, although we have a six-month life expectancy requirement, the people that we've been able to track the date of death for have lived a little longer than that, approximately nine months. As far as how the money is being spent, we haven't tried to track that. We're aware of some special cases where the recipients used the money to pay off their mortgages and pay the last bills before they die. Maybe I'll let Nancy address the fraud question.

MS. BARAN: The regulation prohibits limitations on the use of the funds, so our ability to track how they're used is limited. As Eleanor pointed out, the evidence that we have is mostly anecdotal. We've heard some very nice stories from policyholders who have been able to stay in their homes with their families up until the time they died, because the money was used to pay off second and third mortgages that were about to be foreclosed. We can't, certainly, talk about what the monies were used for in every case.

I am not aware of any cases of fraudulent application for the funds. Our rider provides that the insured has to provide us with proof satisfactory to us, that he or she is, in fact, terminally ill. I haven't seen any problems.

MS. QUERFELD: I just have one comment, also. I think the way the payments are being distributed might be associated with how the individuals are using the proceeds, whether it's one lump-sum payment or it's distributed over time. There might be an association -- but I don't know any studies that are tracking that.

MR. JOEL D. KUNI: I'd like to know whether the accelerated benefits that might be paid by a viatical settlement company would be protected under the current proposed regulation of the IRS.

MR. COLE: Currently, no. When we testified in March 1993 at the public hearing, there were several viatical companies that did testify, and it was heartrending. They did a good job of explaining where the insurance companies fell short, and where they were more understanding of the needs. Personally, I find it hard to expect that the final regulations are going to incorporate viaticals but I did see an article recently, I forget where, but it was in an authentic publication, that said the viaticals were confident that IRS and Treasury wanted to establish a level playing field, and that they would be included in the final regulations.

MS. EDWARDS: You said that the average mortality was nine months. How does Prudential track that? Is that just based on the partial payouts?

MS. HARTLEY: We've tried to find out about the date of death on the full payouts also, using Social Security records. But we don't have 100% knowledge of the date of death on all our claims.

MR. MELVIN J. FEINBERG: I have a question about Prudential's rider. Do you make it available on your second-to-die policy? And if you don't, why not?

MS. HARTLEY: We don't. There are several reasons. We felt that the people who buy the second-to-die policies don't have a real need for a living-needs-type rider. Also the second-to-die policies are fairly complicated, and we didn't want to add additional complications.

MS. BARAN: If I can add to that, I remember why it's not on the second-to-die policy. When we were putting the living needs rider together, we viewed second-to-die as primarily a vehicle for handling estate tax. And having an accelerated payout is inconsistent with using the funds for estate taxes.

MR. COLE: Is anybody interested in when the final regulations might be out? I'll ask the question. And, unfortunately, I can't answer it. Maybe a couple of months ago, I thought they would be out by June 30, 1993, which is supposed to be the effective date. And it certainly looks like that's not going to happen now, which is why we had to write a letter requesting that the regulators move the effective date forward. It would seem like late summer or early fall 1993 is going to be the earliest we can expect them, for a couple of reasons. Number one, Terry Jacobs, whose title is Attorney Advisor in the Treasury Department, is leaving or has just left. He was on the panel and certainly intimately involved with the issuance of the proposed regulations. So that's going to be a problem.

Second, my understanding is that not all of the chairs in the IRS, and maybe even in the Treasury, have yet been filled by the Clinton administration, and some of those chairs need to sign off on final regulations. So, those are two good reasons why it seems like it's at least going to be a few months down the road.