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Session 18OF XXX UPDATE

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Summary: The revised version of the Valuation of Life Insurance Policies ("XXX") has been implemented in many states for two years. In this session, updates on various aspects of XXX are provided. Participants gain an awareness of emerging XXX issues and are better prepared to address XXX valuation.

MR. JAMES F. REISKYTL: I thought I'd give you a quick overview of what XXX is. Regulation XXX is a model regulation that applies to the valuation of all life insurance policies with at least some period of guaranteed premiums. The first version didn't get many state approvals, but the second version has passed in every state. Valuation under regulation XXX involves two approaches, a segmented approach and a unitary approach. The segmented approach takes a look at the underlying experience mortality rates and compares them to the pattern of your premiums. If the two get out of sync, the segment ends. And so you can't, in fact, jimmy the system.

The unitary approach says that you go from the initial date to the end of the period and then take the present value. XXX says you take the greater of those two reserves as the reserve. This XXX applies to all products except variable ones, and it also covers secondary guarantees on universal life. Some think of it strictly as applying to term plans, but it's much broader.

A lot of time was spent on the deficiency reserves and what the standard should be,

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which introduces the concept of X factors. The X factors are company-specific select factors that you can use if your projected experience is better than that of the mortality table. But it also comes with a discipline that says you have to do periodic mortality studies to demonstrate that the X factors you are using are appropriate. If your emerging experience does not support your assumptions, you must change the X factors annually to reflect the experience. Ultimately you may be back to no X factor, depending on your actual experience.

So that's a very quick overview of XXX.

The impact of federal income taxes on statutory valuation standards probably ought to be none or a modest amount because you have to do what's right. You may not agree, but I happen to be a taxman, and they are a consideration for me but not the overriding consideration.

Let me just take you through the basics. There may be conflicting objectives between a good valuation standard and one that meets tax objectives. Our goal of course is to find the solution that meets both needs. So what are those objectives? I would suggest that statutory valuation tries to do what's appropriate. It should use mortality standards defined and tied to a solvency measure. In other words, you provide for some confidence level, presumably about 83-85% for the reserves. It can often also involve a concept known as the deficiency reserves. All this is relatively easy to deal with until you apply these standards to some of the new product types, new guaranteed benefits or new underwriting categories. This creates new challenges. But as long as we have a common understanding of what our reserve objective is, we ought to be able to create solutions. The tax objectives are broken down into two areas. The first involves what you get to take as an increase in reserve deduction. The whole idea of a deduction for a reserve is somewhat contrary to the normal treatment in the tax structure. That is, income in, expenses out, and you don't get to deduct something that is not occurring at this time. Many at the Treasury view the deduction for insurance reserves as an abnormality that should be weakened, so they created a number of rules to limit it.

The other major tax consideration is, how do you define what is taxed as life insurance. I'll get to that in a moment. For deductions, the tax objective is consistent treatment. The goal is that everybody gets taxed about the same way. It relies on the NAIC to establish the reserve method. The NAIC defines the commissioners reserve valuation method (CRVM), and once it's defined, it's immediately effective for tax reserve purposes.

The states set the assumptions, such as the mortality tables and other rules. The Treasury and Congress have decided that, if a company can have more than one standard to establish a reserve, it has to use the one that produces the lowest reserves and deductions.

Then you have issues such as, should we use the select and ultimate table or the ultimate table? What about the applicable federal rate? I'm not going to explain it, but its effect is to force you to use a higher rate, based on a bond index, with a cash value floor.

The second major area, as I said, is the definition of life insurance. Typically, the reserve mortality table has been used as the reasonable mortality table for definitional purposes. The 1980 CSO has been a safe harbor. If your company guarantees something less, then that's what you use.

Tax people have a strong interest in any new valuation mortality table standards. If you create a new table that produces lower reserves, everyone's reserve deductions in the industry are lowered. From the definition of life insurance side, the concern is that the IRS can redefine these any day. They can, although it's unlikely, just come out with a new table.

In fact, they did download the initial 2001 CSO experience table before adjustments, and at one time they were threatening to create their own table. Using their own actuaries, they could come up with the numbers and, once declared, that's the new basis for the definition of life insurance. If you can't meet the next tax criteria because of regulatory requirements, you can see you could have a direct conflict between valuation standards and tax standards as to what is life insurance. And, of course, if it's not life insurance for tax purposes, then the death benefits and the inside buildup of cash values have unfavorable tax treatments.

Hopefully, this gives you a clear understanding of the objectives of two systems: For valuation, develop an appropriate measure of the risks, based on standards that are established; on the tax side, the government has its established objectives.

Next, I'm briefly going to go through an XXX history to provide you with some perspective of the type of analysis that tax people use to review a new table or provision. When we looked at XXX a few years ago, we put together three teams: one team to build an industry model, a second team to consider possible revisions to the select factors and the third team to consider possible limits to where the factors may be used. What we were doing was developing refinements for consideration by those responsible for valuation. We wanted to suggest what changes, if followed, would minimize or, hopefully, eliminate any problems from the tax perspective.

We looked at a variety of things that could be done. We had a team that created the industry model, and we discussed the mortality table version that produces the lowest reserves — we're not talking about a table for any one company, we're talking about it for the industry. For the industry, we had to go out and gather data on universal life sales, different types of term sales, preferred risk and standard sales and all that, and we looked at LIMRA data and other sources. A survey of the

industry was also done to get additional data for this model.

The impact that this proposed table would have on a variety of bases was developed: smokers, nonsmokers, payment modes, and a variety of issue ages and sex. The result was an ability to determine tax reserves under various mortality table assumptions.

The second team took a look at the select factors and said, "Couldn't we do something with the slope of the rates during the select period?" Why did we consider this? Because on the 1980 CSO Table, which also had select factors, it was clearly demonstrated based on the first model that the ultimate mortality table produced lower reserves than those for the select and ultimate table. This conclusion also makes tax calculations a lot simpler.

Therefore, although we could have developed reserves on select and ultimate bases, you would have had a much more complicated system. And this likely would carry over to the definition of life insurance. So it was both simple and appropriate.

The slope of mortality rates was changed to see whether we could ultimately produce a table that would provide an appropriate valuation standard and lower reserves using the ultimate table only.

The third team looked at whether we could limit XXX's use since it was driven largely by the desire of term writers to have lower reserves. Hence, could we only apply it to insurance plans without nonforfeiture values, segments without nonforfeiture values, selected definitional items, etc.? The bottom line was, if we were to restrict it to a limited application, then the probabilities that its use would change the general current conclusions were minimized.

We concluded we could apply the table in all cases and that deficiency reserves were to be based on actuarial judgment. This split is very important in distinguishing reserve standards from deficiency reserves because deficiency reserves are not tax deductible.

We were very, very careful not to call the deficiency reserve structure a minimum reserve structure because, as soon as one does that, you are back into using this table if it produces the lowest reserves — and higher taxes. It is critical that we choose our words carefully.

So we developed a table that was presented to the valuation group for them to think about. And it is my pleasure to report, we were able to find a standard that met both of our objectives: valuation and tax.

Although I've talked about history, history is also current since the criteria do not change. The 2001 CSO table is obviously coming, so we have to repeat the process and analysis. With the new table are new questions. Does XXX stay just like it is?

Does it get modified? Does it get eliminated? What items that were appropriate for the 1980 CSO also apply to the new table? They will likely have to be modified for the new table.

MR. SHELDON D. SUMMERS: The NAIC adopted the current version of the Valuation of Life Insurance Policies Model Regulation, commonly known as XXX, in March of 1999. Since then, there have been questions as to how the model applies to certain policy designs. These questions were brought to the attention of the Life and Health Actuarial Task Force (LHATF) of the NAIC. In response, the task force decided that there was a need for an actuarial guideline.

The proposed guideline, which currently is identified as AXXX, clarifies that reserves need to be established for the guarantees provided by a policy regardless of form. It specifies how certain policy designs should be reserved. The following are examples that are covered by the guideline:

Example 1: A 30-year term policy has a level premium guarantee for the first 10 years. But for the entire 30 years, that premium is illustrated as being level.

The contract specifies that after the first 10 years, you can only raise the premiums if some specified event occurs. The first example of such an event that was brought to the attention of the task force was the decrease of Treasury rates below a certain level.

Here are two choices for how you would reserve this type of policy: (A) reserve as if it were a 10-year level premium guarantee because after the 10th year it's not an absolute guarantee or (B) reserve as if it were a 30-year level premium guarantee. How many vote for A? How many for B? The answer is B, the premium should be treated as guaranteed for the entire 30-year term.

Part of the basis for that decision is that it would be contrary to the conservative nature of statutory accounting to treat this policy the same as one in which the ability to raise premiums is unrestricted.

Example 2: Again we have a 30-year term policy, with the premium guaranteed to be level for the first 10 years. The premium is illustrated to be level for the entire 30-year period. But after the first 10 years, if the premiums are increased, the company has to provide a refund to the policyholder whenever the policyholder decides to terminate the contract.

Here are your five choices: (A) reserve as if it were a 10-year level premium guarantee; (B) reserve as if it were a 30-year level premium guarantee; (C) reserve as if it were a 10-year premium guarantee plus an endowment for the amount of the refund; (D) the higher of B or C, so it would be either a 30-year guarantee or 10 years plus the endowment; or (E) the lower of B or C.

How many for A, B, C, D, E? You're going to be surprised by this one. The answer is that it would be treated as if the premium were guaranteed for the entire 30-year period. The same rationale was used as in the first example, that it's contrary to the conservative nature of statutory accounting to treat this policy the same as one in which the ability to raise premiums doesn't require any additional benefit. There was a lot of discussion on the 10-year plus the endowment alternative, but ultimately the task force decided on choice B being the most appropriate reserve methodology.

Example 3: The policy has a guaranteed dividend or guaranteed refund schedule. You pay the gross premium but you're guaranteed to receive a certain dividend or refund at the end of the period for which you paid the premium.

MR. REISKYTL: Isn't a guaranteed dividend a contradiction in terms?

MR. SUMMERS: Here are your two choices: (A) the guaranteed gross premiums used in the reserves calculations should not be reduced by the guaranteed dividends or refunds or (B) the guaranteed gross premiums should be reduced by the guaranteed dividends or refunds. A or B? B it is.

Example 4: A reentry term product has an initial 10-year rate guarantee with loose or nonexistent reentry underwriting that allows the policyholder to reenter for an additional 20 years, at specified favorable rates. Your reserving choices are to assume a 10-year premium guarantee or a 30-year guarantee. Would you choose 10 years or 30 years? The answer is 30 years.

MR. REISKYTL: What rates did you use? Did you use your rates for this?

MR. SUMMERS: After the first 10 years, you use the specified favorable rates for those additional 20 years.

Example 5: A universal life policy issued to a person age 35 guarantees that if it lapses prior to the 10th policy anniversary, but the policyholder has been paying stipulated premiums, a substitute policy will be issued providing the same amount of insurance coverage at the same stipulated premium for the remainder of the 10-year period, plus an additional 20 years.

This is an actual case that I encountered in my work. If you're paying a stipulated premium of \$20 a month for \$100,000 worth of death benefit and at the end of eight years your cash value goes down to zero, your policy would normally be terminated.

In this case, it wouldn't terminate, and you would instead be provided a substitute policy with a 22-year term for the same \$20 a month and with the same coverage.

The two choices regarding the length of the premium guarantee are: 10-years or

30-years for reserving purposes. The correct answer is that the company has guaranteed coverage for 30 years from the time the initial policy was issued and the reserves established should reflect that guarantee.

Example 6: A universal life policy has a cumulative premium catchup provision, which means that you can, at any time, pay the amount that you are deficient by to reactivate the secondary guarantee.

The two choices for reserving are: (A) you ignore the secondary guarantee if the cumulative premium requirement has not currently been met or (B) you always assume the cumulative premium requirement has been met, but adjust the reserve for the catch-up amount if it hasn't.

How many think that A is the correct answer? B? The answer is that the reserves should be computed as if the stipulated premium requirement has been met, with a reduction to reflect the catch-up amount. Also, a universal life policy with a shadow account may fall into this category if a negative shadow account that later becomes positive still provides a no-lapse guarantee.

Example 7: A universal life policy guarantees coverage will remain in force as long as the accumulation of premiums paid satisfies a secondary guarantee requirement. This also includes universal life policies with shadow accounts. Probably the most controversial issue in the guideline was the calculation of reserves for these types of products.

A universal life policy with a shadow account has, in addition to the typical policy value calculations, another account value calculated usually using more favorable mortality, expense and interest guarantees. As long as the shadow account is positive, the policy is guaranteed to stay in force, even if the policy account or cash value becomes zero.

The three choices for calculating reserves for this type of policy are: (A) a yearly renewable term (YRT) calculation whereby the premium is calculated as the premium that would be necessary to sustain a policy with a zero account balance at the beginning of the year and end the policy year with a zero account balance. Each year it would be expected to increase since the cost of insurance charges goes up.

Choice B is to calculate a level premium using the shadow account assumptions. And choice C is the YRT approach plus a factor to recognize the actual premiums that have been paid up through the valuation date. A, B or C?

The answer is C, the reserve calculation must recognize the actual amount of premiums that have been paid to date. Because this was one of the more controversial issues, the LHATF decided that, although the other components of the actuarial guideline will be retroactive, this prefunding component will not be. Under the current draft, only policies issued on or after the later of the date of the state's

adoption of the revised model on Jan. 1, 2003, will have to include the prefunding component in their reserves.

I expect the LHATF and the Life Insurance and Annuities (A) Committee to adopt this guideline at the June meeting, with final NAIC adoption in September.

This guideline has had a pretty extensive exposure period, and during that period few comments were received on the calculation of reserves for the universal life policy design with the accumulation premium-type of secondary guarantee.

Next, I am going to talk a little bit about X factors. What do we look for at the California Insurance Department when we review an X factor actuarial report? We look for how the X factors were generated and whether they satisfy the necessary tests that are found in the regulation. These are the prospective tests, the retrospective tests and a few other tests.

Actuarial Standard of Practice (ASOP) 40 says that the generation of X factors should be based on anticipated mortality. It should consider the level and trend of actual company mortality experience. There should be no recognition of mortality improvements beyond the valuation date, and, if you don't have available company experience or it's not credible, you may want to use industry experience.

There was one company that calculated the X factors as the maximum factors that result in zero deficiency reserves.

When we first looked at their materials, we asked ourselves, "What is this?" But the company rationale was that its method produces higher X factors than would be derived from experience, and therefore this procedure is more conservative. It wasn't just that they calculated the X factors that resulted in zero deficiency reserves but they actually had compared them to what they would have had if they had based them on the anticipated mortality.

The important thing is that the resulting X factors passed the required tests. My initial reaction was that this procedure violates the spirit of the regulation. And our question was, "Are these X factors justified by anticipated experience?" But, as we thought about it, we decided we really didn't have any objection as long as the tests are passed.

As for the prospective test, for the first segment, the present value of the future death benefits using X factors must be at least as great as the present value of future death benefits using anticipated mortality experience.

In each of the first five years after valuation date, the actual mortality rates obtained by using the X factors must be at least as great as the rates using anticipated mortality experience. The practice note interprets ASOP 40 to require that these tests are to be applied for each X factor class.

As for the retrospective test, the hypothesis being tested is that the X factors are appropriate. This hypothesis would only be rejected if actual claims fall outside of a given confidence level in the distribution of expected claims.

The distribution of the expected claims is determined using company exposure and statistical simulation, usually Monte Carlo methods or a method developed by Harry Panjer.

Here's what we're seeing. Most companies perform satisfactory statistical analyses. Sometimes, though, there are issues as to the interpretation of the results. Often, individual X factors are said to be appropriate, even if actual claims fall well outside the required range. This is because the data are often not credible. As a result, X factor classes are often aggregated.

Other tests are that no X factor can be less than 20% and X factors cannot decrease in successive years for a particular valuation date. These tests are easy to satisfy by forcing the factors to comply.

As for our general critique of compliance with the process, we believe most companies seem to follow the letter of the regulation. In some cases we think that more attention may need to be paid to the ASOP. And we really would sometimes like greater discussion of the results and the reasons for the conclusions that the actuary reaches, especially when the results are borderline or worse.

MR. LLOYD M. SPENCER JR.: My remarks will be aimed primarily at the work that was done to prepare the life practice note related to regulation XXX along with some other current issues.

As for background, I was a member of the Academy's former Committee on Life Insurance Financial Reporting, which had responsibility for developing nonbinding life practice notes.

The practice notes use an FAQ format to provide folks with a highlight of what's accepted actuarial practice in the industry in terms of potentially controversial areas. We highlight model regulations, particular state regulations, and the ASOP developed by the Actuarial Standards Board to give you some practical guidance on what's going on and how other practicing actuaries are addressing these issues. If you've ever read through the practice notes, you'll note that there is a liberal use of statements to the effect that many actuaries or some actuaries or most actuaries believe a particular point.

In particular I want to focus on the XXX practice note, and I've pulled out a few questions of interest.

Question 11 from that note is about mortality experience used for X factors calculated using the combination of policy count and face amount experience. If you have readily available information, based on policy counts, the question asks

whether that is good enough for the work that you're doing or do you need to focus on face amount experience? There is clear guidance in the Standard of Practice (SOP) that you should be looking at issues in terms of face amount. In practical experience, though, looking at a policy count basis for a mortality study is inherently more conservative than looking at a face amount-based study, given the increasingly stringent level of underwriting as applied to large face amount contracts as opposed to smaller face amount contracts.

You can also run into some issues as you look at the volatility in claims in a particular year. If you have a very large policy issued to an individual, and that person happens to die within that calendar year, it can produce some very unusual results in your mortality study. It's really a blending of face amount and policy count analysis to provide some excellent guidance to you as to where potential problems lie in an X factor schedule or in a mortality function in general. And ruling out the use of policy count just limits the tools that are in your arsenal. We encourage you to use both approaches.

That also begs the question of credibility. One thing that comes up throughout the X-factor process is whether you have enough business here that's credible. One rule of thumb in terms of credibility that we use in practice is that we need generally 100 claims. But, given the nature of our term business that we write, it can take several years to accumulate 100 claims on a substantial block of business.

One way to expedite the process of achieving partial or full credibility is to include in your analysis the emerging experience of similar business issued prior to the advent of regulation XXX. Adjustments may be necessary to account for differences in the underwriting or marketing of such plans, but sweeping in the maximum amount of relevant business will help expedite the process of achieving full or partial credibility.

Regardless, it will require the liberal use of actuarial judgment when you have relatively few claims. And I don't think anybody would complain if your company is experiencing relatively low numbers of claims; that's a good problem to have. You don't want to achieve credibility the hard way.

Question 13 under the model regulation is, "Can X factors vary by valuation year?" The guidance here is very clear that, as of a particular valuation date, you cannot use an X factor that is lower than what's being used for that date. One of the X factor schedule tests established by regulation XXX is ensuring that X factors are not decreasing in successive durations. But when you move out to the next valuation year, you certainly can change your view of the anticipated mortality. This can ultimately lead to a revision of your existing schedule of X factors up or down, recognizing that your assumption was perhaps overly aggressive or conservative when you first established it. How many of your companies or your client companies have actually made a change in the anticipated mortality underlying their schedule of X factors? Has anybody tackled it? And was that retroactive to all

of your business that's subject to XXX or just for business going forward?

FROM THE FLOOR: It was retroactive in the application.

MR. SPENCER: It provides an opportunity for companies to reflect certainly more experiences available as your mortality experience plays out over time and perhaps you sweep in other blocks of business. As you consult with consulting actuarial firms or reinsurers, you may be able to sharpen up your overall view of anticipated mortality. And again this may result in an increase or decrease to your existing schedule of X factors.

Certainly it can be reflective of secular improvement in mortality and, in particular, improvement in the insured lives population. Again, we caution you to think about mortality improvement; it's not a one-size-fits-all factor. Improvement varies and tends to be focused on the groups that can benefit most from mortality improvement.

Improvement varies by attained age, by gender and, arguably, by the level of underwriting performed. The more extensive the underwriting process, the better the view of that individual's risk of death over some future time frame. For an applicant who applies for insurance from your company on a nonmedical basis, there could exist the potential for significant mortality improvement over time because medical advances tend to benefit those individuals who might have a condition that would prevent them from obtaining insurance while undergoing a more extensive form of underwriting.

The process of revising your X factor schedules will become very prominent over the next few years. One could view this as revising your schedule of X factors on a prospective basis only. But potentially, for valuation purposes, you're viewing this as changing your anticipated mortality for all your in-force and new business, to minimize the impact on your valuation system of maintaining multiple X factor schedules.

Question 18 is, "When testing the appropriateness of X factors, how should classes of business be defined?" which I have generically labeled a question of aggregation. There are a few points to consider here. The admonition in the SOP section 3.4 is that policies should have similar underwriting experience characteristics. There is some other loose language in the ASOP that potentially suggest that policies may have similar characteristics. But the "should have" is a point that carries more weight here.

Think also about the definition of an X factor class. The ASOP in section 2 defines X factor class as a group of policies under one or more plans of insurance to which a single set of X factors apply. And then in section 3.6 in the periodic assessment, assessing the appropriateness of anticipated X factor mortality, this should be completed for each X factor class in an aggregate for all of the classes combined.

I've heard of companies that potentially use a schedule of X factors that vary at the lowest practical level of usage, that is, by product, underwriting class, gender, tobacco use and duration from issue. Other companies may vary X factors by only a broad group of issue ages, that is, issue ages under 40 and issue ages over 40.

They set X factors practically for pricing purposes and for valuation purposes at that level, but then intend to justify their X factor experience at a higher level only. They state that their X factor class is really defined at the product level, and they have X factors that vary slightly underneath that. But for practical purposes, I have an X factor class that's at a much higher level, and that's the level I will evaluate my business at.

Those of us who drafted the life practice note came down clearly on the view that X factors are defined as those cases indicated earlier — cases where you're actually varying your X factor schedule. So testing your X factor classes at the lowest level at which they practically vary is the place to perform that first test.

And I would certainly recommend that you perform that test at each level above that as you consolidate potentially across plans, across underwriting classes and across tobacco use, ultimately, until you evaluate your X factor at the company level.

Taking that X factor analysis now down to the lowest level that's possible is consistent, I believe, with the spirit of XXX as it was drafted.

Ultimately, if you're using a consolidation to set your X factor classes, you've introduced the potential for mix of business risk as you potentially roll things up. Perhaps, using one set of X factors for your 10-year term, 15-year term and 20-year term, you have an inherent mix of business assumptions that underlie it. You anticipate sales to be consistent with your prior plans, or potentially you make use of distributions recommended by a consultant.

What actual distribution plays out and ultimately would give rise to mortality expectations could be different from the mix of business that you assume in the construction of the schedule. So we would caution you to consider that as well.

I want to highlight a few additional resources that are at your disposal, in particular, the SOA Survey Subcommittee's survey in March 2002, which is available on the SOA Web site. It provides you with a look at how a broad cross-section of companies in the industry has dealt with XXX over time.

I want to remind you that the best way to reach a conclusion of resolution on particular issues is an open discussion of those issues. I recommend contacting state regulators not only in your state of domicile, but also in other states to open up that dialogue and be proactive; it's a very positive thing. Make use of the consulting actuaries at your disposal, and make sure that you are putting your best foot forward when it comes to dealing with regulation of XXX.

MR. ANDREW BOYER: In example 8, in guideline AXXX, what exactly does the phrase "accumulation of premiums paid" mean? Does that apply only to the case like a shadow account where you're adding interest and deducting some sort of mortality charge? Or does it also apply where all you're doing is adding the actual and minimal premiums and comparing them to see if the test is met that way?

MR. PEAVY: In the basic question, it was simply trying to describe the arrangements that do exist. It was trying to describe whatever manner the secondary guarantee functions in.

So, if that accumulation is without interest, that's what that phrase means. If the accumulation is with interest, I think that's what the phrase means. If there are charges deducted, that's what that phrase means.

MR. SUMMERS: It's whatever the language in the contract says as to how you calculate the accumulation of premiums.

FROM THE FLOOR: I have two questions. Is there still any discussion on simplifying item 8, steps 3 through 8? And, also on the implementation, are there certain sections of the model that will be applicable as soon as NAIC adopts it? Or are there certain sections that the states are going to have to adopt? Some of this is brand new, some of this is just a clarification of what was already there. But I thought there were parts of item A that were not necessarily already incorporated into the original XXX. How is all of this going to be implemented as far as an effective date?

MR. SUMMERS: The task force believes that everything in the guideline is actually interpretation. Some companies, however, were doing their reserve calculations differently, and they had talked to their regulators who might have agreed on their methodology at that time. As a result, it was decided that steps 3 through 8 of item 8 would not be retroactive. But the rest of the guideline would be.

FROM THE FLOOR: My question was about the adoption. Since we're assuming that XXX will be in effect as soon as the guideline is adopted, why is there an adoption needed by the states?

MR. PEAVY: We have state regulation of insurance, so there has to be some form of state adoption. The question is, how is that accomplished. But you asked two questions. Let me respond to your first question first. You said, "Is there any consideration being given to simplifying items 3 through 8?"

The consensus among the task force is that this has been exposed long enough, and there's a great desire not to do any more changes, unless there is a really fundamental error. So, I don't think there's any movement at this point to simplify or change any of the language in this actuarial guideline.

The other questions was, "When will it be applied in the states?" That's a

complicated issue. So far, the actuarial guidelines have been incorporated into the codification standards, and when that process occurs, then, yes, it will have an impact in those states that have some sort of automatic adoption process for codification. If a state operates in some other fashion, then presumably they would have to take some explicit action to implement this guideline. That's why it takes a state action in some form, but that form can vary from state to state.

MR. REISKYTL: Sheldon, you said some companies say that X factors are appropriate even if the claims fall well outside the range. I'm curious. Do you slap them around the head when they do that or do you say that's good enough for now? What do you do when they say, "Here's an X factor that was supposed to be supported by something," and it clearly isn't?

MR. SUMMERS: What I was talking about was when you really don't have credible data. You might have one claim for a large amount that causes claims to be outside the acceptable range. In those cases, it doesn't automatically mean that you have to reject the hypothesis and say that the X factor is wrong. You just have to give a good explanation as to why you still think that the X factors are appropriate. Maybe you have some other business that is different in some minor aspects and for which you have credible experience.

But it's not easy. This is one of the circumstances in which the actuary has to make a real effort to decide whether the X factor continues to be justified or whether it should be changed.

MR. REISKYTL: And that's all very logical. Who has the final say? Suppose you and the company disagree. Do you have ultimate power or does the company? Suppose I hear your explanation, but I don't find it credible. When September 11 happened, you had a lot of claims. Suppose I don't think another September 11 is going to happen. Hence, I tell you not to take that into account when you do it. But suppose you have a fairly extensive database and it's inconsistent with X factors. What do you do then? Who makes the final decision?

MR. SUMMERS: Doesn't the regulator always have the last say?

MR. REISKYTL: I have a question for Lloyd. In these classes when you combine them, it almost seems like an oxymoron because if they're classes, they're classes. Suppose you combine all ages because you have so few claims at the moment. If you have five claims, how far can you break them down? Just because you have accepted these broad classes today, doesn't mean they'll be acceptable in the future. I just wanted to see if you would agree with that.

MR. SPENCER: Retrospectively, looking at your X factor classes, I'm not sure that it inherently takes more time to perform an analysis of emerging X factor experience at the lowest level than it would to roll things up and look at a higher level.

Mechanically, while there may only be five claims out there for a given calendar year, it could be bad news if all five of those claims came in a particular X factor class that would require some additional explanation of what was going on. Go through the process at the lowest level today and then, as you roll things up, take some intermediate steps between the lowest X factor class level and the block level. And provide some support for answering the questions that others might be asking you.

Take that next logical step as you prepare your report for the regulators to review. If you do have five claims, and they fall in a particular X factor class, look at things on a by-number basis and see if that is your problem because of an excess claim size. And look at successively higher levels along the way. Again, you're trying to source out whether you have a material misstatement in your assumption, and that assumption, again, could play itself out over time in different ways. Also, sweep in older blocks of business. Sweeping across blocks of business that are subject to regulation XXX is another way to get at that issue. The industry has a large amount of level-premium term business sitting out there that's been issued from 1995 on. It's fairly homogenous in its nature and design. Let's look at that entire block of business and get to the point of credibility much more quickly than we would just looking at one or two years' issues along the way.

FROM THE FLOOR: Does the rate guarantee that the reinsurer gives to the company affect the periods in some of those examples you had in the guidelines you were using?

MR. SUMMERS: Yes, as far as the reserve that the assuming company sets up.

FROM THE FLOOR: So the reinsurer has some say in insuring your 30-year product with a 10-year guarantee? In one of those examples where we went through all the permutations that came out, you could still use a 30-year period for the guaranteed premium. What would happen if the reinsurance premium was only guaranteed for one year and it was a 90% quota share?

MR. SUMMERS: The ceding company's reserve would be unaffected by it. The question comes down to the reserve credit. There are some exemptions in the model, but we argue that the credit should be limited to what the assuming company is going to be setting up. What type of reinsurance are we talking about, just coinsurance?

FROM THE FLOOR: Yes.

MR. SUMMERS: With coinsurance, I'm not sure you would have that situation and still have a treaty that's compliant. With coinsurance, if the ceding company is guaranteeing a rate to the policyholder and the reinsurer has the option of charging a higher rate to the ceding company, that would be a violation of the regulation on

reinsurance. To qualify for a reserve credit on the coinsurance, you can't have a situation where the reinsurer can deplete the ceding company of surplus. And that could occur in your example if the ceding company has to pay more to the reinsurer than it collects from the policyholders. So that situation could result in no reserve credit.

MR. KEITH DALL: Mark, you had talked about the states having to adopt the actuarial guideline AXXX down the road. What is the likelihood of the states adopting it? Is it 50 states? 40 states? 30 states? And then, if you can, also comment on actuarial guideline XYZ.

MR. PEAVY: In terms of how many states are going to adopt this guideline, your guess is as good as mine. I would assume the vast majority of the states would defer to the judgment of the NAIC as a whole, and the LHATD in particular.

MR. SUMMERS: I think you indicated before that not all states feel they have to adopt the guideline in order to apply it.

MR. PEAVY: They do have to adopt it; it's just the precise form of adoption that differs. Some of the states have laws that say "we live by codification," or words to that effect. So that constitutes adoption, even though it is not an explicit adoption of the guideline.

In terms of XYZ, there has been concern expressed over whether it should be a guideline or a regulation. The general consensus is that there's going to be more discussion on that issue in Philadelphia. Goodness only knows what will happen, but probably what will happen is that it will be re-exposed in the form of a regulation, just to see if that changes the level of consensus.

I would assume that it wouldn't result in a materially substantive change to the document, but we won't know that for sure until we actually get into the mechanics of it.

MR. REISKYTL: Sheldon, you said earlier that the issue involving the shadow accounts was very controversial. Has that controversy now died down so that it is unlikely to reappear in states in different forms?

MR. SUMMERS: Of course, we can't predict what exactly is going to happen and what issues might come up. But we've given the guideline ample exposure in the hope that it would be looked at and, if there were any problems with the calculations in any way, that they would be brought to the attention of the task force. There was some work done by a few companies in putting together some examples. But other than that, there hasn't been too much discussion lately on the actual calculation.

I assume you're talking about the actual calculation. The issue of whether there

should be a prefunding component or not was decided and has been over for a while, as far as the task force is concerned.

MR. PEAVY: Jim, that's not to say that everybody is happy with that decision. But I think that people are just worn down by the process. There may be a sense among the people who didn't support that particular approach in example 8 that what they have is the best they're going to get. But time will tell.

FROM THE FLOOR: My experience has been when pricing term products with regulation XXX, the problem is not the methodology. And it's not even so much the deficiency reserves because of the X factors, but it's the basic reserves driven by the 1980 CSO being horribly redundant.

Based on what I've seen for super-preferred and preferred risk classes, at least, that remains overly redundant. Is there any discussion of putting X factors on basic reserves or some other way to make that regulation a little less punitive on super-preferred and preferred products?

MR. PEAVY: The answer is yes.

FROM THE FLOOR: Can you elaborate?

MR. PEAVY: Did that discussion produce any results that can actually be implemented? The answer is no. I think the general feeling was there would just be too many classes and too many different ways that companies go about establishing the classes ever to hope to have an objective way of classifying business.

FROM THE FLOOR: Isn't that what the X factors are?

MR. PEAVY: Yes, but it's a compromise. You have it for the deficiency reserves, but you don't have it for the basic reserves. And that was not a simple or easy consensus. This discussion went on for years, and these compromises have a way of evolving. It took years for people to get comfortable with the X factor concept that is incorporated in regulation XXX.

MR. REISKYTL: I'm going to add a couple of comments from a tax perspective. You don't want to apply X factors to the basic reserves that create a new mortality table. The ACLI had a group looking at super-select. Unfortunately, no one has ever succeeded in defining what it is. If you have a definition, we are most anxious to see it and see if it receives general agreement in the industry. So, step one is to define what it is you're talking about. The second step is to decide what, if anything, to do about it.

I was part of a group at the ACLI that was looking at this issue with about a half a dozen companies, many of whom have a super-duper term policy. That effort has

just faded away with the new CSO table. Whether it's due to exhaustion or satisfaction, I cannot assess it.

If you have an interest, we would be more than interested to talk to you because the chair of the committee has concluded and reported to the ACLI actuarial committee that it no longer has an interest in pursuing this particular effort. If there are people who have an interest in it, it could be reconstituted. Obviously, a nonmember of ACLI would have to do it in some other forum.

This topic is one of those things that gets talked about a lot, but what it really comes down to is the need for a proposal to review. The final part of my comment is: Come up with a specific proposal that you believe may be generally acceptable to the industry. When we see such a proposal, we can measure it against our criteria that I mentioned earlier in this presentation to see if it holds up.

I understand all of the arguments for lower reserves and higher profits, and that is to be saluted. But you must understand that we have to have a definition, a proposal and an interest in the industry to get something done.

MR. PEAVY: Don't get me wrong. I do appreciate your comment, too, but if you do have the desire to follow up on Jim's suggestion, just be willing to spend several years of your life devoted to the project and then building that consensus.

MR. REISKYTL: We were meeting fairly regularly, and then as people took a look at the 2001 CSO, they either found that they could live with it or that the remaining problem wasn't serious enough to put the needed effort into it. It does take a lot of work, but don't misunderstand me, I'm very interested in a solution if there is one.

It's like many things; it sounds simple, but it isn't. I think it's a very good process because it produces results that have a lot of consideration among the regulators, the industry and other interested parties. The net result is a good working product. It may not meet any one particular criterion totally, but it meets the general objective and satisfactory solutions.