

SOCIETY OF ACTUARIES

Report on Life and Annuity Living Benefit Riders

Considerations for
Insurers and Reinsurers



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Project Overview

The Society of Actuaries (SOA) Product Development Section and Reinsurance Section, along with the Committee on Life Insurance Research have sponsored this research paper to investigate life and annuity living benefit riders and their implications from both a direct writer and a reinsurer perspective. The SOA engaged a team at Milliman led by Carl Friedrich to conduct this research.

The scope of the research includes the following products:

- Accelerated Death Benefits (ADB) for Chronic Illness
- ADB for Terminal Illness
- ADB for Critical Illness
- Life/Long Term Care Insurance (LTCI) Accelerated Benefits
- Life/LTCI Linked-Benefit Plans
- Annuity/LTCI Linked-Benefit Plans
- Annuity Enhanced Payout Benefits triggered by a qualifying health condition

Please note that Guaranteed Lifetime Withdrawal Benefits (GLWBs), Guaranteed Minimum Income Benefits (GMIBs) and other living benefits not triggered by a covered health event are not included, nor are annuities that merely waive surrender charges when a health event occurs.

This paper has several goals in relation to each living benefit rider type: to define the various living benefit riders listed above, to provide historical sales data and general filing requirements, to explore how underwriting and administration is handled, and to comment briefly on the overall level of claims activity experienced thus far compared to pricing expectations. In addition, it includes a review of the direct and reinsurance pricing implications of the riders to the extent they impact policyholder optionality and base plan financial characteristics. This paper includes perspectives developed through the experience of the authors, and includes executive summaries of a survey conducted by the SOA and Milliman of 34 direct writers, and interviews that Milliman conducted with 8 reinsurers. In addition, a detailed report is available that covers the findings of the survey. Please note that in some cases the number of respondents to the survey questions was low, so this may not be indicative of the total market. In addition, where Milliman complemented the survey information with its own knowledge of these markets, that commentary reflects the authors' experiences which may not be representative across the entire market.

With respect to the direct writer survey, the scope of the research included:

- Sales
- Benefit Features
- Compensation
- Underwriting
- Benefit Charge Structure
- Claims
- Administrative Handling
- Reinsurance
- Pricing Implications
- Reserves
- Target Surplus
- Agent Licensing/Training
- State Filing

The survey was conducted of individual life and annuity companies offering living benefits. Questions were jointly developed by Milliman and the Project Oversight Group. The survey was administered in two parts: Part I: Sales and Part II: All Other Topics.

This survey included questions relative to the following living benefit categories:

- Life Insurance benefits
 - Accelerated Death Benefits (ADB) for Chronic Illness
 - ADB for Terminal Illness
 - ADB for Critical Illness
 - Long Term Care Insurance (LTCI) Accelerated Benefits
 - LTCI Linked-Benefit Plans
- Annuity benefits
 - LTCI Linked-Benefit Plans
 - Enhanced Payout Benefits triggered by a qualifying health condition

Guaranteed Lifetime Withdrawal Benefits, Guaranteed Minimum Income Benefits, and other living benefits not triggered by a qualifying health condition were not included in the survey. The scope of the survey also excluded annuities that merely waive surrender charges when a qualifying health condition occurs.

Responses to Part I and Part II of the survey were submitted to the SOA. The SOA then forwarded Part II responses to the researchers, and summary level information for Part I for some sections of the survey. Note the respondents to Part I and Part II of the survey are not the same. While the majority of respondents participated in both Part I and Part II of the survey, there were some respondents that decided to participate in only Part I or Part II.

A summary of the complete survey results may be found in the Appendix II “Report on Life and Annuity Living Benefits Survey”. A brief summary of the key findings of the survey is included in this report for each of the living benefits covered by the survey.

The reinsurer interviews were conducted by Milliman consultants, with separate sessions for each of the eight reinsurers identified in this market. A series of questions was posed with respect to positioning of their reinsurance in each of these product lines. We also secured input on the concerns that these reinsurers had about the various products, pricing considerations, contractual issues, and administrative factors. The results are presented in this paper at the end each of product group section.

Please note that although the report is written in present tense in a number of sections, the information provided is purely based on data as of the time of the survey responses (mid 2014) or shortly thereafter.

Accelerated Death Benefits for Chronic Illness, Terminal Illness, or Critical Illness

I. Defining Accelerated Death Benefits

An accelerated death benefit rider attached to a life insurance policy means, in its simplest form, that when the insured meets certain conditions stipulated in the rider and submits a qualifying claim, the insurance company will make a payment (or payments) to the owner while the insured is still alive, in exchange for some or all of the death benefit proceeds that would otherwise be payable at death. Therefore, the life insurance death benefit available to the named beneficiary(ies) on the life insurance policy is reduced as accelerated benefit payments are made to the owner. The conditions stipulated in the rider that the insured must meet before receiving accelerated benefits determine the type of accelerated death benefit the company is offering: terminal illness, chronic illness, and/or critical illness.

The flexibility of the accelerated death benefit concept is appealing to consumers who realize that a terminal or long-term illness can be very expensive. Accelerated death benefit riders added to life insurance policies allow the possibility of meeting either of two separate consumer needs: the need to provide a death benefit to heirs, and the need to pay bills during a serious critical or long-term illness, albeit with a reduction to the benefits that would ultimately be available to life beneficiaries.

Per the experience of the authors of this report, many life insurers do not offer long-term care insurance, are not comfortable with long term care insurance risks, or have concerns about the requirements of the long-term care insurance regulations that govern qualified LTCI ADB riders. For these companies, it is an easier path to offer accelerated death benefit riders that are regulated under NAIC Model Regulation 620, the Accelerated Benefits model regulation (or a state's own accelerated death benefit regulation, if that state has not adopted the NAIC model regulation). These accelerated death benefit riders are not subject to the LTCI rules under Internal Revenue Code Section 7702B or to state regulations pertaining to LTCI, and in fact cannot be marketed as LTCI. Therefore, they are not subject to the requirements of a variety of forms and applicants' signatures mandated for LTCI. It is typically assumed that agents do not need a health insurance license or LTCI training in order to sell ADB for chronic illness, critical illness, or terminal illness riders.

In addition to NAIC Model Regulation 620, other standards that insurance companies typically consider when developing and defining their non-LTCI accelerated death benefit riders include Internal Revenue Code Section 101(g) and regulatory requirements from the Interstate Insurance Product Regulation Commission (the IIPRC). Since these three items have such an influential role in the development and definition of these riders, they are discussed in detail below.

A. *NAIC Model Regulation 620: Accelerated Benefits Model Regulation*

As previously mentioned, accelerated death benefit riders need to comply with NAIC Model Regulation 620, assuming it has been adopted in the states in which the insurer is conducting business. NAIC Model Regulation 620 applies to all accelerated benefit provisions of individual and group life insurance policies, except those subject to the Long-Term Care Insurance Model Act and Regulation. For this reason, insurers offering accelerated benefits in the states governed by this regulation incorporate much of the language from the Model Regulation into their riders.

In addition to defining an accelerated benefit, this model regulation defines a qualifying event under which the company will pay the accelerated benefit as one or more of the following:

1. *A medical condition that would result in a drastically limited life span as specified in the contract, for example, 24 months or less;*
2. *A medical condition that has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die;*
3. *A condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of his or her life;*
4. *A medical condition that would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, one or more of the following:*
 - a. *Coronary artery disease resulting in an acute infarction or requiring surgery;*
 - b. *Permanent neurological deficit resulting from cerebral vascular accident;*
 - c. *End stage renal failure;*
 - d. *Acquired Immune Deficiency Syndrome; or*
 - e. *Other medical conditions that the commissioner shall approve for any particular filing; or*
5. *Other qualifying events that the commissioner shall approve for a particular filing.¹*

Based on the authors' experience, number one above is widely used by insurers as the qualifying condition (or benefit trigger) allowing payment to an insured for an accelerated death benefit for terminal illness. However, insurers often require the insured's life expectancy to be 12 months or less, instead of the less stringent 24 months or less allowed in the regulation. Insurers may also incorporate any of the qualifying events listed above into their riders to provide an accelerated death benefit.

¹ Italicized items are from [NAIC Model Regulation 620](http://www.naic.org/store/free/MDL-620.pdf)
(<http://www.naic.org/store/free/MDL-620.pdf>)

Item number two is a benefit trigger sometimes seen in critical illness riders, for example paying an accelerated benefit when an insured requires a major organ transplant or is in a comatose state. Item number three, which basically requires the insured to be permanently confined in an eligible institution such as a nursing home, was often used in early chronic illness riders as a qualification to receive accelerated benefits. These riders were sometimes referred to as “nursing home confinement riders”. In addition to item two which is sometimes used, the fourth qualifying event is almost always used as a benefit trigger in ADB for critical illness riders. In recent years, the fifth alternative of using another trigger approved by the Commissioner has been utilized frequently. In particular, many companies have chosen to utilize benefit triggers that are also used in LTCI riders, such as triggers based on an Activities of Daily Living impairment or cognitive impairment. (This will be discussed in more detail in the following sections on *Internal Revenue Code Section 101(g)* and *Interstate Insurance Product Regulation Commission*.)

Other provisions that can typically be found in accelerated death benefit riders are also a result of the NAIC Model Regulation 620, such as:

- The rider must include the option to take the accelerated benefit as a lump sum. Note that ADB for critical illness riders always pay a lump sum payment whenever an accelerated death benefit is triggered. However, it is possible to design these riders to pay lump sum payments for multiple benefit triggers or multiple occurrences of a single benefit trigger.
- There is a requirement to obtain an acknowledgement of the accelerated benefit payout from an assignee or irrevocable beneficiary.
- No restrictions are allowed on the use of the accelerated benefit proceeds.
- If any death benefit remains after an accelerated benefit payment, any accidental death benefit provision must not be affected.
- The plan may not be marketed as long term care insurance.
- A disclosure statement is required stating that accelerated benefits may be taxable and assistance should be sought from a personal tax advisor.
- The effective date of the accelerated benefit provision is effective for accidents on the date of the policy or rider, and is effective for illness no more than 30 days following the effective date. (Note: this sets the rules for maximum waiting periods).
- The Model Regulation allows insurers to pay a present value of the face amount, with the calculation based on any applicable actuarial discount appropriate to the policy design. The maximum interest rate used shall be no greater than the greater of:
 - The current yield on 90-day Treasury bills, or
 - The current maximum statutory adjustable policy loan interest rate.
- Alternatively, the Model Regulation allows insurers to accrue an interest charge on the amount of the accelerated benefits. The maximum interest rate used is the same as detailed above. The interest rate accrued on the portion of any lien that is equal to the contract’s cash value at the time of acceleration must not be more than the contract’s policy loan interest rate.

NAIC Model Regulation 620 also details the requirements for the actuarial memo and reserves, in addition to various disclosures to policyholders and beneficiaries/assignees.

B. Internal Revenue Code Section 101(g)

As noted above, more recent accelerated benefit riders on the market are using triggers similar to those in long term care riders. Insurers have looked to number five, “other qualifying events” within the qualifying event definition of Model Regulation 620. Instead of using the first four benefit trigger definitions from Model Regulation 620, newer accelerated benefit riders on the market look to IRC Section 101(g), which allows insurers to use the definition of a chronically ill individual provided by IRC Section 7702B as a qualifying event to pay accelerated benefits to an insured. This reflects the activities of daily living (ADL) triggers or cognitive impairment as defined in IRC Section 7702B, and as augmented by any state requirements.

Accelerated benefit riders that incorporate IRC Section 101(g) often provide accelerated death benefits upon either terminal illness or chronic illness. In this regard, IRC Section 101(g)(4) provides definitions for a terminally ill individual and a chronically ill individual. A terminally ill individual means an individual who has been certified by a physician as having an illness or physical condition that can reasonably be expected to result in death in 24 months or less after the date of certification (note that this allows for provisions that define terminal illness as life expectancy of less than 24 months, such as 12 months). A chronically ill individual “has the meaning given such term by section 7702B(c)(2); except that such term shall not include a terminally ill individual.” This indicates to insurers that although chronic illness riders are generally not qualified LTCI riders, IRC Section 101(g) still requires chronic illness riders to use a definition no more liberal than the chronic illness benefit trigger definition provided by 7702B.

Section 7702B(c)(2) states:²

A. In general

The term chronically ill individual means any individual who has been certified by a licensed health care practitioner as –

i. Being unable to perform (without substantial assistance from another individual) at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity,

² Italicized items are from IRC Section 7702B(c)(2), *Treatment of Qualified Long-Term Care Insurance*.

ii. Having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (i), or

iii. Requiring substantial supervision to protect such individual from threats to health and safety due to severe cognitive impairment.

Such term shall not include any individual otherwise meeting the requirements of the preceding sentence unless within the preceding 12-month period a licensed healthcare practitioner has certified that such individual meets such requirements.

The activities of daily living are defined as eating, toileting, transferring, bathing, dressing, and continence.

To our knowledge, insurers have not incorporated the disability trigger (number ii. above) into chronic illness riders. However, triggers i. (2 of 6 ADLs) and iii. (cognitive impairment) are regularly seen in current chronic illness accelerated benefit riders where the insurer's intention is for the benefits paid to be treated for federal tax purposes as accelerated life insurance death benefits under IRC Section 101(g). Note that in the last few years, many of these plans also required an expectation of permanence of these conditions. See item (1)(e) (i) in the following *Interstate Insurance Product Regulation Commission* section.

It should be also noted that insurers offering accelerated death benefits still need to comply with NAIC Model Regulation 620 or corresponding state versions of the model, even if they choose to use the federal tax benefit trigger requirement from IRC Section 101(g).

The annual re-certification by a licensed healthcare practitioner that insurers require on 101(g) chronic illness riders to verify that the insured still meets the definition of chronically ill originates from the above 7702B definition.

We expect that the benefit triggers found in ADB for terminal illness or chronic illness riders, which rely on IRC Sections 101(g) and 7702B, as discussed above, would be treated similarly if included in an ADB for critical illness rider. However, since IRC Sections 101(g) and 7702B do not specifically address critical illness riders, there are many additional benefit triggers that are often included in an ADB for critical illness rider, for which no clear tax guidance exists. Some ADB for critical illness riders are referenced in Private Letter Rulings issued by the IRS, which under specific circumstances may provide insight as to how the IRS might view accelerated death benefit payments for tax purposes. However, these rulings are not definitive guidance and therefore, owners of ADB for critical illness riders are typically advised by the insurer to consult with a personal tax advisor regarding tax treatment of these proceeds.

C. Interstate Insurance Product Regulation Commission

The Interstate Insurance Product Regulation Commission (“IIPRC”) was formed to enhance the efficiency and effectiveness of the way insurance products are filed, reviewed, and approved allowing consumers to have faster access to competitive insurance products. The IIPRC develops Uniform Standards for the form and actuarial requirements for individual and group annuity, life insurance, disability income and long-term care products. Insurers may then file their products for review and approval for compliance with the Uniform Standards. States that enact the Compact-enabling legislation become members of the IIPRC and agree insurers can sell products approved by the IIPRC in their state pursuant to Uniform Standards rather than state-by-state product requirements. Providing there are Uniform Standards in place covering an applicable product, a single submission to the IIPRC may, upon approval, allow an insurer to use that product in all Compacting states.

As of October, 2014, 44 jurisdictions had joined the IIPRC. They include:

Alabama	Kentucky	New Hampshire	Texas
Alaska	Louisiana	New Jersey	Utah
Arizona	Maine	New Mexico	Vermont
Arkansas	Maryland	North Carolina	Virginia
Colorado	Massachusetts	Ohio	Washington
Georgia	Michigan	Oklahoma	West Virginia
Hawaii	Minnesota	Oregon	Wisconsin
Idaho	Mississippi	Pennsylvania	Wyoming
Illinois	Missouri	Puerto Rico	
Indiana	Montana	Rhode Island	
Iowa	Nebraska	South Carolina	
Kansas	Nevada	Tennessee	

It should be noted that states may “opt out”, or decline to participate in a given IIPRC Uniform Standard. Although this seldom occurs, it has happened with the Long Term Care Standards. For example, when Arizona joined the IIPRC in 2014, it opted out of participating in the Long Term Care Standards. Likewise, Nevada previously opted out of the Long-Term Care Standards, but recently reversed itself and now accepts Long Term Care submissions through the IIPRC.

The applicable Uniform Standard for accelerated death benefit features is the Additional Standards for Accelerated Death Benefits. The ADB Uniform Standard was originally adopted in December 2006 and was recently amended in August 2014 pursuant to the IIPRC’s five-year review process (which requires review of Uniform Standards and its Rules every five years for clarifications or changes). A redlined version of the Uniform Standard for Accelerated Death Benefits showing these amendments which are effective for filings submitted on and after the effective date of December 4, 2014 can be found on the IIPRC Record (on the IIPRC website

www.insurancecompact.org) under the “Standards History” link. Some notable clarifications and amendments include adding provisions to address features commonly found in tax-qualified accelerated death benefit riders and to address the requirements for notice to the applicant at the time of application for the IIPRC-approved accelerated death benefit rider.

Qualifying Event

Specifically, the IIPRC Uniform Standard states that *qualifying event*³ means the following:

- (1)(a) *Terminal Illness. A medical condition that is reasonably expected to result in a drastically limited life span for the insured. The company’s definition of a drastically limited life span shall have a minimum of “6 months or less” and a maximum of “24 months or less”, and shall be specified in the form;*
- (1)(b) *A medical condition that requires extraordinary medical intervention, such as major organ transplant or continuous artificial life support, without which the insured would die;*
- (1)(c) *A condition that is reasonably expected to require continuous confinement in an institution, as defined in the form, and the insured is expected to remain there for the rest of his or her life. The term “institution” shall be defined in the form;*
- (1)(d) *A specified medical condition that, in the absence of extensive or extraordinary medical treatment, would result in a drastically limited life span; or*
- (1)(e) (i) *A chronic illness defined as permanent inability to perform, without substantial assistance from another individual, a specified number of activities of daily living (bathing, continence, dressing, eating, toileting and transferring), or permanent severe cognitive impairment and similar forms of dementia. The company’s definition of chronic illness shall not require the inability to perform more than two activities of daily living.*
- (1)(e) (ii) *For the purposes of complying with the requirements of IRC Section 7702B and IRC Section 101(g) (“federal requirements”), chronic illness may also be defined as prescribed in these federal requirements, such as:*
 - (I) *For activities of daily living, requiring the inability to perform such activities to be for a period of at least 90 days;*

³ Italicized items in this section are from the IIPRC, *Additional Standards for Accelerated Death Benefits*, IIPRC-L-08-LB-I-AD-3, adopted August 15, 2014, and made effective December 4, 2014.

- (II) *For Periodic payments, requiring that within the preceding 12-month benefit period a licensed health care practitioner has certified that the insured meets the requirements of IRC Section 7702B(c)(2)(A); and*
 - (III) *For cognitive impairment, requiring substantial supervision.*
- (2) *A Terminal Illness qualifying event must always be included. The company may also provide accelerated benefits upon the occurrence of other qualifying events. If the accelerated death benefit provides multiple qualifying events, the insured meeting the conditions of any one specified qualifying event shall be sufficient to entitle the owner to accelerate the death benefit.*

Items (1)(a) through (1)(d) above are derived from the NAIC Accelerated Benefits Model Regulation 620. Item 1(e) gives the insurer some flexibility in that it offers two separate alternatives with chronic illness as the qualifying event. As part of the five-year review process, the definition of qualifying event was revised to add the definition of “chronic illness” from Sections 7702B and 101(g) for tax-qualified ABR products. The Uniform Standard for Accelerated Death Benefits now allow tax-qualified ABR forms to use the definition of chronic illness provided in item (1)(e)(ii) without also have to comply with the original definition of chronic illness that required an expectation of permanence. Further revisions to address federal requirements under this IRC provisions included adding a new provision in Section 3(C)(G) to address the requirements with respect to periodic payments and lump sum, including per diem and re-certification.

One requirement the IIPRC qualifying event definition imposes on insurers seeking approval through the IIPRC is that a terminal illness qualifying event must be issued with any ADB for chronic illness or ADB for critical illness rider (see Item (2) above). It is therefore not surprising that we have seen more insurers offering a combined chronic illness/terminal illness ABR or combined ADB for critical illness/terminal illness rider, in order to receive approval from the IIPRC. The terminal illness benefit may be in the form of a rider separate from the ADB for chronic illness or ADB for critical illness rider forms, as long as the insurer certifies to the IIPRC that the ADB for chronic illness rider or ADB for critical illness rider will not be issued without the ADB for terminal illness rider.

Waiting Period/Elimination Period

The IIPRC Uniform Standard also includes requirements under the *Accelerated Death Benefit Provisions* section, within *Qualifying Events*:

The IIPRC will not approve accelerated death benefit forms containing a waiting-period requirement. It also does NOT allow insurers to require that the cause of the qualifying

event manifest itself or be diagnosed after the rider is issued or that the rider be in force past the incontestable period.

The IIPRC Uniform Standard allows an elimination period not to exceed 90 days in definitions (c) and (e)(i) from the qualifying event definition. As a reminder, definition (c) refers to continuous confinement in an institution while (e)(i) is the chronic illness definition that requires permanence and is not derived from IRC Section 7702B and 101(g). During the elimination period, the insured is required to meet the terms of the qualifying event without interruption.

Definition (e)(ii) is the chronic illness definition defined by IRC sections 7702B and 101(g) and as such, insurers may look to these sections for the specific requirements. An elimination period of at least 90 days is allowed in this qualifying event definition.

The IIPRC Uniform Standard does not allow for an elimination period when the remaining qualifying event definitions are used. Due to this restriction, there are certain qualifying events often included in a stand-alone critical illness policy that you would not usually find included in an ADB for critical illness rider. For example, when coma is included as a qualifying event in a stand-alone critical illness policy, there is usually a requirement that the coma persist for a minimum amount of time before a benefit would be triggered. Requiring a coma to persist for a minimum amount of time is not permissible when filing with the IIPRC and therefore this benefit is often excluded.

Insurers filing with the IIPRC should also remember to include in their Accelerated Death Benefits filing a sample of the two disclosure forms showing the effect of benefit payment on other benefit provisions. The Uniform Standard for Accelerated Death Benefits have always included a requirement to file for approval of the disclosure form to be provided at the time of claim. As a result of the five-year review process, the Uniform Standard for Accelerated Death Benefits were revised to add a new requirement to file for approval the disclosure form to be provided at the time of application. The Uniform Standard for Accelerated Death Benefits includes the content requirements for these forms. With respect to the disclosure form at the time of application, the IIPRC maintains a comprehensive listing of states where state law may require a written statement be provided to the applicant at the time of application and approval by the IIPRC of the statement pursuant to the Uniform Standard for Accelerated Death Benefits satisfies these requirements. The drafting note after Section (2)(C)(1) states that the written statement required by the states listed in the chart shall comply with these Uniform Standards as approved by the IIPRC.

Note that the IIPRC Uniform Standards for Accelerated Death Benefits cover several other topics including, but not limited to, benefit amount, benefit design options, effect of benefit payment on other benefit provisions, exclusions/restrictions, expense charges, incontestability, payment options, payment procedures, reinstatement, and termination. Therefore, insurers filing chronic illness, critical illness or terminal illness riders with the IIPRC should review these Uniform Standards in their entirety.

Benefit Exclusions

The Uniform Standard for Accelerated Death Benefits, as originally adopted, does not permit exclusions or restrictions for an accelerated death benefit that are not also exclusions or restrictions in the policy. During the five-year review process, industry representatives requested that this provision be changed to allow exclusions not in the base policy, such as exclusions based upon alcoholism or drug addiction. The IIPRC recommended no change to the existing provision during this comment period. This provision prohibiting exclusions outside the policy is also included in the Group Uniform Standard Accelerated Death Benefits. The primary issues are related to mental and nervous exclusions and drug and alcohol abuse.

Other Items

There are some other items of interest from the IIPRC's "Additional Standards for Accelerated Death Benefits for Individual Life Insurance Policies":

- Mix and Match is allowed: These standards may be used in combination with State Product Components as described in Section 111(b) of the Operating Procedure for the Filing and Approval of Product Filings.
- Self-Certification is not allowed: These standards may not be filed using the Rule for the Self-Certification of Product Components Filed with the IIPRC.
- A description and justification for expense charges associated with the accelerated death benefit and the maximum expense charge should be included in the actuarial memorandum. If such charges exceed \$250, a detailed explanation must be included. Companies may deduct one expense charge for each acceleration and must state the maximum expense charge in the acceleration request form. If any index used in determining the interest or expense charges is discontinued, the substituted index is subject to approval by the IIPRC.

Another point of clarification involves the incidental test for accelerated death benefit riders. The actuary must certify at the time of filing that for triggers other than terminal illness, the accelerated death benefits and premiums are incidental to the life coverage. The actuary is not required to provide ongoing certifications for a form once it is approved. The certification submitted with the filing should include a statement that the assumptions used to calculate net single premiums (i.e., the present value of benefits) with and without the rider will be reviewed at least annually to ensure that the value continues to be incidental. If the value of the benefits are no longer incidental based on current anticipated experience factors, the company must discontinue offering the accelerated benefit form which is no longer incidental.

II. Structure of Benefits and Costs

Chronic Illness or Critical Illness

There are three different pricing/benefit structures used in the design of these riders:

Discounted death benefit approach: The insurer pays the owner a discounted percentage of the face amount reduction, with the face amount reduction occurring at the same time as the payment. This is currently the most common approach in the market for chronic illness benefits. It avoids the need for charges up front or other premium requirements for the chronic illness rider, because the insurer covers its costs of early payment of death benefits (i.e., prior to death) via a discount factor. Premium requirements or cost-of-insurance charges for the remaining life coverage are naturally reduced into the future by virtue of the reduction in future benefits. This approach is rare for critical illness riders.

Lien approach: The payment of accelerated death benefits is considered a lien or offset against the death benefit of the policy and access to the cash value is restricted to any excess of the cash value over the sum of any other outstanding loans and the lien. Future premiums or charges for the coverage are unaffected, and the gross cash value continues to grow as if the lien had not occurred. If there is no lien interest rate being charged to the client, it is difficult for this structure to be financially self-supporting. Even with the use of lien interest charges, the prescribed lien interest rates are generally low and certain portions of the lien amounts outstanding may be non-admitted assets on the insurance company's statutory statements. Still, it should be noted that some ADB for critical illness riders will use this approach.

Dollar-for-dollar death benefit reduction approach: When an accelerated benefit is payable, there is a dollar-for-dollar reduction in the death benefit and a pro rata reduction in the cash value based on the percentage of death benefits accelerated. Premium requirements or cost of insurance charges for the remaining life coverage are naturally reduced into the future by virtue of the reduction in future benefits. Benefit payments are typically reduced by inherent loan repayments that result in a preservation of the loan-to-cash-value relationship. This approach always requires an explicit charge for both the ADB for critical illness and chronic illness riders, other than very unusual situations where the trigger definitions would be so restrictive that the impact to profits would be viewed as trivial.

Under all three options, but especially under the first two options, an administrative fee may be charged when claiming the accelerated benefit. Loan balances are usually reduced at the time of acceleration, typically on a pro rata basis, and the acceleration payment itself is reduced correspondingly. The periodic payment amount may be predetermined as a percentage of the life face amount, or the amounts may be determined at the time of claim at a lower level by the owner, within certain constraints.

Terminal Illness

For terminal illness riders, insurers may use the lien method or the discounted death benefit approach; per Section X below, the latter is somewhat more common among the survey respondents. If filed with the IIPRC, insurers are not allowed to charge any premium or cost of insurance (COI) charge for the terminal illness benefit. (See IIPRC *Standards for Accelerated Death Benefits*, # 4 under *Design Options*.) However, an administration charge may be deducted from the accelerated benefit proceeds at the time of claim.

III. Policyholder Taxation

Per the survey, insurers usually design their chronic illness and terminal illness accelerated death benefit riders to be compliant with Internal Revenue Code (IRC) Section 101(g), Treatment of Certain Accelerated Benefits, as opposed to long-term care riders, which are generally governed under IRC Section 7702B, Treatment of Qualified Long-Term Care Insurance. However, some insurers have chosen to design an LTC ADB rider that complies with Section 101(g) instead of Section 7702B, or that complies with both sections.

As they are usually deemed to be death benefits, accelerated benefit payments received under Section 101(g) riders are intended to qualify for favorable tax-treatment under Section 101(g), or in other words, are intended to be tax-free to the policyholder. It should be noted that Section 101(g) imposes a number of other requirements. For example, benefits received over the per diem HIPAA (Health Insurance Portability and Accountability Act) requirements are taxable. It should also be noted that whether an individual's accelerated benefit payment in fact actually qualifies for this favorable tax treatment will depend on a number of specific circumstances. Therefore, the owner of such a plan is typically advised by the insurer to consult with a personal tax advisor regarding tax treatment of these proceeds.

Early chronic illness riders used number two, three and/or four of the qualifying event definitions from the model regulation, without the tax rule definitions for chronic illness (and thus provided no assurances that Section 101(g) would apply to claims under such riders).

IV. Impact on Policy Pricing – Anti-Selection, Mortality, Policy Persistency and Premium Persistency Issues

This is covered in Appendix II that presents the results of the direct writer survey. Direct writers surveyed did not generally believe that these riders presented significant concerns in terms of the impact on policy pricing. The most notable issue on this topic emerged in discussions with reinsurers pertaining to the mortality question when chronic illness and terminal illness are combined, per Section XII below.

V. Impact on Reinsurance Pricing and Administration

This is covered in Sections IX through XIV below and includes commentary about some of the reinsurance issues presented by these riders.

VI. Underwriting Considerations

Some companies with chronic illness riders do not issue the rider on policies with substandard table ratings—for example, a Table 4 or 5, or higher—and some do not issue the rider on policies with medical flat extras or reinsured cases. Additional underwriting and an application supplement are more likely to be put to use with the dollar-for-dollar death benefit reduction approach. This makes sense considering that riders using this structure have more risk exposure that is not offset by revenues generated via discounted ABR payouts or lien interest charges. In contrast to this stricter approach, some companies that offer the discounted death benefit approach do little or no additional underwriting for chronic illness riders except perhaps at advanced ages, such as over 70, where some additional screening is conducted to evaluate cognitive skills or ADL status. Companies do not typically underwrite in regard to terminal illness or nursing home confinement riders.

VII. Other Features

Base Product Platform

Accelerated death benefit riders are offered with all different types of base life insurance plans, including whole life, universal life, indexed universal life, and variable universal life insurance. Other than for terminal illness riders, it is less common for these riders to be offered on term plans, although it has been done. Based on the authors' experience, because there can be the need for special rules or factors in different base plans, many companies confine their ADB for critical illness or chronic illness riders to a limited set of products. This is less of an issue with terminal illness riders.

Residual Death Benefits

The purpose of a residual death benefit feature is to guarantee that some life insurance coverage is available for the life beneficiary even if contract values have been drained because of LTC or chronic illness needs. The death benefit payable is the greater of the residual death benefit or the remaining policy death benefit. One thing to keep in mind is that the meaning of residual death benefit in chronic illness riders may vary by company or by product. Some chronic illness riders do not allow for acceleration of the full death benefit amount, so that there is something remaining in order to pay the residual death benefit. However, with most LTCI riders with independent benefits, the full death benefit amount may still be accelerated even though what they call a residual

death benefit is provided upon death as an additional benefit for no additional explicit charge. Some companies do not offer a residual death benefit on the chronic illness rider, allowing acceleration of up to 100% of the death benefit. This is normally seen with those chronic illness riders following the dollar-for-dollar death benefit reduction approach.

Terminal illness riders generally do not offer a residual death benefit provision. However, there may be a limit placed on the percentage and/or amount of the death benefit that can be accelerated due to terminal illness; in that case, there will be a remaining death benefit even when the terminal illness benefit is elected.

Waiver of Charges:

If a company decides not to assess a premium or charge upfront for its chronic illness rider, there are no rider charges to be waived. Products with chronic illness riders without an upfront charge normally do not waive underlying charges for the base policy at the time of a chronic illness claim.

Those riders that have a chronic illness rider charge that is deducted monthly from the account value, or a separate rider premium, sometimes have a waiver-of-costs provision for the base policy, the rider, or the cost of all coverages.

Several terminal illness riders have maximums on the amount that will be paid out under the rider, such as “the lesser of 75% of the remaining benefit amount or \$250,000”. In those cases where the terminal illness benefit does not pay out 100% and the policy remains in-force after the terminal illness benefit is paid, future policy charges are often handled by basing the new charges upon the reduced policy values following the terminal illness benefit payment. Similarly, critical illness riders do not typically waive charges on any remaining coverage amounts.

Per the experience of the authors, often times ADB for Critical Illness riders do not permit multiple benefit triggers as well as not providing for a re-occurrence benefit. In this case, once an accelerated benefit payment is triggered, it is typically paid out as a lump sum benefit and the rider then terminates. This scenario is quite common for ADB for Critical Illness riders and therefore a waiver of rider charges provision is typically not necessary.

ADB for Critical Illness rider designs with explicit rider premium charges may remain in force after an initial acceleration benefit is triggered when the designs which allow for a residual death benefit and either permit multiple benefit triggers or include a re-occurrence benefit. Although a waiver of rider charges provision would provide a valid benefit, these rider designs are less likely to contain this provision when compared to other types of accelerated death benefit riders, such as ADB for chronic illness or long-term care riders. Similarly, these designs are less likely to provide for a waiver of base charges provision when compared to other accelerated death benefit rider types. This

may be in part due to the absence of claim event which would persist after the accelerated death benefit is triggered, as in the case with a chronic illness triggering a benefit. For example, once a heart attack occurs, an ADB for Critical Illness benefit may be payable, however, a heart attack is not considered to continue and therefore there would be less need for waiving premiums over a period of time as a result of a heart attack.

VIII. Administrative Considerations: New Business and Inforce Policy Administration, Claims Administration, Outsourcing Considerations

Based on the authors' experience, accelerated death benefit riders for ADB for critical, terminal and chronic illness riders are viewed by insurance companies as being easier to administer than most LTCI benefit riders.

A terminal illness benefit is normally paid only once per policy, making the administration simpler than other accelerated death benefits. Chronic illness riders generally require more administrative work than terminal illness riders, as most insurers offering chronic illness riders allow for a "lump sum" accelerated benefit payment once per year, with an annual re-certification requirement. However, there are some chronic illness riders in which insurers have chosen to keep it simple and only allow one accelerated benefit payment for the life of the policy. The complexity of administration for ADB for critical illness riders falls somewhere in between that for ADB for terminal illness or ADB for chronic illness riders. If no multiple benefit triggers or re-occurrences of a prior benefit trigger are permissible, then it is similar to an ADB for terminal illness rider in that only one benefit payment will be paid per policy. Likewise, if either multiple benefit triggers or re-occurrence of a benefit trigger is allowed, then additional complexity of administration is introduced. Most of the ADB for critical illness riders are designed to only pay a one or two lump sum benefit payments over the entire life of the policy in order to limit complexity in administration, particularly if they want to avoid manual administration of claim payments.

Chronic illness riders to this point generally have required that the chronic illness is expected to be permanent, in contrast to LTCI riders, which do not require the illness to be permanent. As a result, the probability of a claim for a chronic illness rider is reduced from that under an LTCI rider.

The fact that NAIC Model Regulation 620 does not allow restrictions on how the insured uses the benefit payments can make claims processing less complex for accelerated death benefit riders, because the company does not have to collect bills/receipts from the insured before making the payments. This is appealing to many companies. (Note: Companies offering LTCI riders and linked-benefit policies have the choice of offering various benefit payment methods which may or may not require bills regarding LTC services at the time of claim.) However, companies offering ADB for critical illness or chronic illness riders must still have a process in place to certify the chronic illness claim. Those ADB for chronic illness riders that offer the insured

the choice of an annual lump sum (instead of paying the full benefit in one payment) will need to administer annual re-certifications.

NAIC Model Regulation 620 requires that at claim time, the insurer must send a statement showing any effect that the accelerated payment will have on the policy's cash value, accumulation account, death benefit, premium, policy loans, and policy liens. The statement must also indicate that the receipt of accelerated benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits. In addition, receipt of an accelerated benefit payment may be taxable and assistance should be sought from a personal tax advisor. When a previous disclosure statement becomes invalid as a result of an acceleration of the death benefit, the insurer needs to send a revised disclosure statement to the policy owner or certificate holder and irrevocable beneficiary. When the insurer agrees to accelerate death benefits, the insurer shall issue an amended schedule page to the policyholder or notify the certificate holder under a group policy to reflect any new, reduced in-force face amount of the contract.

The survey summary includes information about outsourcing of services used across the industry.

IX. Executive Summary of Direct Writer Survey Pertaining to ADB for Chronic Illness

Nineteen of the 34 survey participants responded to questions relative to ADBs for chronic illness. Three of the 19 provided responses for more than one ADB for chronic illness design. A total of 23 plans were reported for ADB for chronic illness.

Total first year premium was reported by 17 survey participants relative to ADB for chronic illness benefits. The 17 participants reported sales for 21 plans. Total first year premium refers to the total actual dollars of premium received in the period for the entire policy for all policies in which the chronic illness accelerated death benefit is included. The table below shows total sales by calendar year reported by survey participants, as well as the average and median sales per plan.

Appendix II Figure 1: First Year Premium – ADB for Chronic Illness Riders

Calendar Year	Number of Plans	ADB for Chronic Illness Sales (\$ Million First Year Premium)		
		Total	Average	Median
2011	11	\$681.7	\$62.0	\$24.9
2012	17	\$1,334.6	\$78.5	\$16.9
2013	21	\$1,196.9	\$57.0	\$14.9

Breakdowns by issue age and distribution channel are included in the detailed reports. The average issue age in 2013 was 59.

ADB benefit riders for chronic illness are attached to a variety of base plans, with the most common being UL (17), WL (10), IUL (8) and VL (6), and even 2 on term. Twenty-two are offered on single life plans, and four on second-to-die products. The survey did not explore how these riders were priced on second-to-die coverages. This can be challenging since the presence of chronic illness on one life may occur many years or decades in advance of the death of the healthier life, with significant implications relative to the savings normally expected when accelerated benefits reduce future death benefits.

Eight plans use the lien approach, all charging interest, six use dollar-for-dollar death benefit reductions, and nine use the discounted death benefit approach. It is notable that two discount based on underwriting at time of claim, while the rest are based on age at claim or age and duration since claim. As noted in the Reinsurer Interview section later, there are a number of concerns about the viability of the discounted death benefit approach unless underwriting is conducted at the time of claim.

Triggers almost always include a licensed health care practitioner (LHCP) certification, and 2 of 6 ADLs or cognitive impairment. Seven require permanent nursing home confinement, and only 3 require a plan of care. Fourteen of 23 require an expectation of permanence. It will be interesting to see if the market changes in this regard in the future in response to the new standards adopted by the IIPRC that provide an option for a benefit trigger definition that does not include a permanence requirement.

18 of 20 plans use a hard dollar cap or percentage of face cap to accelerated benefits. 12 of 21 allow benefits to exceed HIPAA limits. 17 offer a single lump sum payout, while 20 offer periodic payouts (8 annual, 14 monthly, and other variations).

19 require no additional underwriting, and the others use a supplemental app, cognitive screen, or a prescription drug screen. 10 of 11 indicate they underwrite in-house, and 21 handle claims in-house.

Virtually all of the 23 plans have incidence of claims within expectations, with 11 having lower claims than expected, but credibility is generally low.

13 of the plans are reinsured and ten are not.

In many jurisdictions, a terminal illness benefit must be included along with the chronic illness benefit. Survey participants were asked if the pricing of the chronic illness benefit in those cases reflects reduced utilization of the chronic illness benefit. The pricing of only one of the 23 chronic illness plans reflects such a reduction. This seems noteworthy, particularly under the discounted death benefit approach. Specifically, terminal illness benefits would typically pay only for claimants with a short life expectancy, usually less than one year. As such, chronic illness claimants on policies with a terminal illness rider are likely to be much healthier than they would be in the absence of a terminal illness provision. Thus, the discounts that would be needed to

preserve the company's profits would be much larger (i.e., with lower payouts available to policyholders).

Additional active life reserves for these riders are rarely held. Three respondents indicated they hold an additional active life reserve. One respondent using the lien approach noted that liens in excess of reserves are non-admitted assets. Four respondents indicated they held a disabled life reserve for these riders when additional benefit installments are expected.

Extensive information on state variations and other topics are included in Appendix II.

X. Executive Summary of Direct Writer Survey Pertaining to ADB for Terminal Illness

We received 25 survey responses to questions relative to ADBs for terminal illness. Four of the 25 provided responses for more than one ADB for a terminal illness design. A total of 35 plans were reported for ADB for terminal illness.

The survey did not request sales data for ADB for terminal illness plans. Many of the riders are automatically included with the base chassis, and there is no incremental premium for the rider itself.

The majority of terminal illness accelerated benefits are intended to qualify as death benefits under IRC Section 101(g). Twenty-six of the 35 plans are intended to qualify under 101(g), and, interestingly, the remaining nine are not intended to qualify.

Accelerated death benefits under terminal illness riders are offered on a variety of base life insurance product chassis. The majority of terminal illness benefits are offered on multiple base product chassis. Twenty-two of the 35 plans are offered on more than one chassis.

Of the 35 terminal illness plans, 26 are offered on a single life base product only. Eight of the remaining nine are offered on both a single life and a second-to-die base product. The survey did not explore how companies price for this benefit on second-to-die plans when one insured may still be very healthy. The final plan is offered on a single life and a first-to-die base product.

The benefit payment approach used by survey participants in terminal illness ADB plans is varied. Twenty of the 35 plans use the discounted death benefit approach. An additional 14 plans use a lien approach.

Of the 35 ADB for terminal illness plans, it was reported that 26 only offer a lump sum benefit mode. Six additional plans offer a lump sum benefit mode, plus an additional option.

Various actions that trigger the payment of accelerated death benefits for terminal illness were reported by survey participants. The most common triggers are:

- the existence of a medical condition that is reasonably expected to result in death in a certain number of months; and
- written notice of claim.

To be eligible for ADB for terminal illness, 28 of the 35 survey plans require a life expectancy of no more than 12 months. One plan requires a life expectancy of no more than six months and three no more than 24 months. Other companies have requirements that vary by policy.

The overall average administrative expense charge for terminal illness ADB plans is \$108 over 32 plans (of which 13 have no administrative expense charge and 19 reported positive charges). The table below shows a summary of the amounts assessed as administrative expense charges on the 19 plans that assess a charge, reflecting the maximum reported.

Appendix II Figure 34: Administrative Expense Charges Among Plans with a Charge

Number of Plans	Average	Median	Minimum	Maximum
19	\$182	\$150	\$100	\$300

The overall level of terminal illness claims from 2010 through 2013 relative to that assumed in pricing was at or below expected levels for all plans that were reported.

For 24 plans, the ADB is not reinsured, and for 11 plans it is reinsured.

When the base life plan is reinsured, but the ADB for terminal illness is not reinsured, there may be implications that should be considered. For four plans, it was reported that there is simply a timing difference (relative to the payment of the claim) when this occurs. For another plan, no reinsurance payment is received unless a death claim is ultimately incurred. Another comment received indicated that if the benefits that were accelerated exceed the cash value and the policy lapses before the insured dies, the direct writer would not receive reimbursement of the difference from the reinsurer. The final comment was that there is no material impact in this situation.

Additional reserves or target surplus for the terminal illness benefit are rarely held. For one of the 34 plans, a non-admitted asset is held if the lien is greater than the reserve. For one plan, a separate additional reserve is calculated.

Significant filing variations were reported for 17 terminal illness ADB plans. Details are in Appendix II.

XI. Executive Summary of Direct Writer Survey Pertaining to ADB for Critical Illness

Only three of the 34 survey participants responded to questions related to accelerated death benefits (ADB) for critical illness plans. All three participants submitted responses for a single ADB for critical illness plan resulting in a total of three ADB for critical illness plans included in the responses.

ADB for critical illness plans are offered on a variety of base life insurance product chassis. All three participants responded that their plan was offered on multiple base product chassis which have recurring premiums, and that the plan is automatically included with the base policy.

Two benefit payment approaches used for ADB for critical illness plans were reported in the survey results. Two survey participants reported that their plan uses the lien approach, while the remaining survey participant reported that they use the discounted death benefit approach for their ADB critical illness plan.

Several critical illnesses were reported to trigger the payment of an accelerated death benefit for the ADB for critical illness plans reported on by survey participants. All three survey participants reported that the benefit amount for the ADB for critical illness plan does not vary based on the critical illness trigger. The table below includes a list of these critical illness triggers. Other triggers exist in the market.

Appendix II Figure 47: Critical Illnesses that Trigger an Accelerated Death Benefit

Critical Illness	Number of Critical Illness Plans Reported
Cancer (excluding skin cancer)	2
Heart Attack	2
Stroke	2
Organ Transplant	2
Renal Failure	2

All three survey participants reported that the benefit payment for the ADB for critical illness plan is payable as a single lump sum payment, though one survey participant did report that they may agree to payment in some other manner if requested. Two of the three survey participants reported that they do not pay multiple benefits due to multiple benefit triggers, while the remaining survey participant reported that their plan does pay multiple benefits for multiple benefit triggers. All three survey participants reported that the plan does not include a re-occurrence benefit under the ADB for critical illness plan.

All three survey participants reported that the ADB for critical illness plan has no explicit charge for the benefit. Two of the plans assess an administrative charge when the death benefits are accelerated.

All three survey participants provided responses regarding the overall level of claims from 2010 through 2013 relative to that assumed in pricing. Two of the three reported that claims were close to expected, and the remaining survey participant responded that the question was not applicable. Of the three survey participants, only one reported that they used reinsurance for the ADB for critical illness plan.

All three survey participants responded that no additional active life reserve is held for the ADB for critical illness plan, and none of the participants establish a claim reserve or target surplus for the ADB for critical illness plan.

Of the three ADB for critical illness plans reported, only one plan was reported as governed under Section 101(g) of the IRC.

XII. SOA Research Report – Chronic Illness – Reinsurer Interviews

In addition to the direct writer surveys, Milliman conducted a series of interviews of eight reinsurers. More reinsurers are moving to pay benefits at the time of rider claim for these plans, but various concerns were expressed about direct writers' expectations or lack of consistent reinsurance practices in this area.

Prior practices included allowing reinsurers to pay their share of benefits at the time of death based on a net amount at risk (NAR) frozen at the time of rider claim, based on a floating NAR between rider claim and death, or not paying at all. It was noted that under some structures, the reinsurer can end up paying out more than the entire coverage in force at death.

Some pay on policyholder surrender after a rider claim. One reinsurer noted that at lapse they have to figure out what to pay under some unusual circumstances, e.g., situations where the CV is greater than the accelerated benefit.

It was observed that when the base policy is reinsured, but not the accelerated benefits, the reinsurer could collect premium on the life coverage with no payouts. If the reinsurer pays at death only, there are questions about the correct charge for the mortality risk between rider claim and death.

It was apparent that there was a goal for the reinsurers to assure alignment with the direct writers and to participate in the way the direct writer wants them to participate. Some reinsurers want to include examples in the treaties, but that hasn't always occurred. It was noted that many in force treaties do not clearly address the details of the reinsurance premium and payout calculations.

Some reinsurers' underwriters review direct writers' standards to see if there is any need to adjust mortality assumptions for anti-selection by those applicants including the rider in their coverage.

On discounted death benefit designs, reinsurers typically rely on the discounting done by the direct writer, but check the calculations before entering into a treaty. One problem is the discounted value used by direct writers is based on the PV future death benefits - PV direct writer's premiums (not reinsurer's premium). Some reinsurers add an extra charge to their quotes in these cases to account for the disconnect.

The IIPRC requires that terminal illness must be included with the chronic illness rider, and this has implications under some designs. Some reinsurers have expressed concerns about those pricing implications. Specifically, the biggest concern is under the discounted death benefit method, where the implication of individuals opting for a terminal illness benefit (typically discounted by only a nominal amount) implies that the claimants that elect chronic illness benefits will have less severe conditions, and longer life expectancies, which must be anticipated in the mortality table used for discounting. That in turn reduces the payout percentages (or put another way, deepens the discount) relative to the face amount reduction. This can create an anti-selective policyholder option, with only those in the best health electing the offer.

There are some market conduct considerations related to low percentage payouts under the discounted death benefit approach. This is more of a concern on the direct side, since reinsurers are a little more protected.

In the past, very few people have taken a discounted death benefit offer, since the offers have not been viewed as attractive. As a result, some reinsurers question whether chronic illness discounted death benefits are ultimately viable without underwriting at the time of claim.

The decision to use the chronic illness definition from 7702B and 101(g), as allowed by the IIPRC under the revised Uniform Standard, by some insurers for their chronic illness rider may cause some reinsurers to be less comfortable with the chronic illness risk, due to the fact that this definition does not require the illness to be permanent.

There is also some concern about certain riders being issued without what reinsurers consider to be best practice risk controls.

There is a big distinction between riders that charge a premium versus those that don't. Companies charging a premium are now viewing this as a way to grow premium, and a way to provide value to the client.

Despite some of the concerns above, reinsurers have become more active in fully participating in these risks.

XIII. SOA Research Report – Terminal Illness – Reinsurer Interviews

In contrast to the comments on chronic illness riders, reinsurers appear to be more comfortable with participating in terminal illness risks. These riders have been common much longer than chronic illness riders in general. In addition, given that life

expectancies are usually within one year with these riders, or at most two years, some of the concerns that exist with chronic illness riders are largely mitigated.

All eight reinsurers indicated that they are reinsuring these riders, although many noted that they are paying benefits at death (or in one case, upon lapsation after acceleration but prior to death). Several noted that they have migrated from a policy of reimbursing only at the time of death to payments at the time of acceleration. One noted that on its YRT treaties they pay at the time of death, but on coinsurance deals they pay at the time of acceleration. Several reinsurers noted the need to assure that treaties are clear as to when reinsurers are supposed to pay, at death or upon acceleration.

All reinsurers rely on the terminal illness benefit calculations of the direct writer, but a few made specific comments indicating that they review the discounting formulas prior to signing the treaties. More of the reinsurance deals are structured on a YRT basis, but it would appear that this is largely in line with the underlying reinsurance treaty on the base plan.

Some reinsurers alluded to freezing the net amount at risk with respect to reinsurance charges between the time of acceleration and the time of death. Virtually all reinsurers use the same limits on terminal illness as they would on the underlying life coverage.

XIV. SOA Research Report – Critical Illness – Reinsurer Interviews

Six reinsurers indicate that they are reinsuring critical illness riders. One other reinsurer said they were willing to participate but haven't seen much need. The vast majority of the deals are YRT, typically with a maximum at the base plan limit. Many of the reinsurers explained that for many treaties they don't actually provide reimbursement to the direct writer until the time of death, but some have moved to paying at the time of acceleration. In addition, one commented that they would pay at the time of lapsation after an acceleration.

Most reinsurers are relying on any discounting calculations used by the direct writer.

Long Term Care Benefits: Long Term Care Insurance Riders and Life/LTCI and Annuity/LTCI Linked-Benefit Plans

I. Defining Long Term Care Accelerated Benefits and Life/LTCI and Annuity/LTCI Linked-Benefit Plans

Long Term Care Insurance Accelerated Benefits

There are several life insurance companies in the marketplace today that offer the option of attaching a long term care insurance accelerated death benefit rider to a life insurance policy. Companies sometimes refer to them as Long Term Care Riders (LTC Riders) or Long Term Care Services Riders. Upon the insured qualifying as a chronically ill individual, part or all of the full life insurance death benefit may eventually be accelerated through the ABR, to help pay for qualified long term care expenses received under a plan of care. If the full death benefit has not been paid out under the LTC rider, the beneficiary will receive the remainder upon the insured's death. Mechanically, these riders work in a similar manner to chronic illness riders that use the dollar for dollar death benefit reduction approach, but the benefit payments are typically monthly (as opposed to typically annually on chronic illness riders) and many of them are based on an expense reimbursement model, where payments are limited to expenses incurred under a formal plan of care. As noted earlier, chronic illness riders are not allowed to restrict the use of proceeds from the insurance, and thus cannot cap benefits to expenses incurred.

Agents normally need both a life and a health insurance license in order to sell these riders. Many states also require that agents go through LTC training before selling these riders, and some mandate continuing LTCI education requirements. There are also numerous compliance requirements for insurers to meet when selling LTCI riders, as they are governed under the NAIC Long Term Care Insurance Model Act (640) and Regulation (641). Although many states have adopted the NAIC model, insurers will also need to research individual state regulations when appropriate. Life insurance policies or riders containing accelerated long-term care benefits do not have to comply with all sections of the NAIC LTCI Model Act and Regulation, because an exemption is provided within certain sections. (To be discussed in more detail later in this paper.) However, the compliance requirements may still be somewhat overwhelming to insurers who have no experience in selling and administering LTCI.

In addition to the NAIC LTCI Model Act and Regulation, other standards insurance companies typically consider when developing and defining their LTCI riders include Internal Revenue Code Section 7702B (although a few LTCI riders have been designed using Section 101(g) also) and filing requirements from the IIPRC.

Life/LTCI and Annuity/LTCI Linked-Benefit Plans

Linked-benefit plans are also known by many in the marketplace as “hybrid” plans. Explained at its most basic level, linked-benefit plans use either a life insurance or annuity policy for the base plan, and offer the customer both an LTCI accelerated benefit rider (ABR) and an EBR (Extension of Benefits Rider) for the purpose of addressing long term care needs. The ABR on this type of policy works basically the same way as the LTCI ABRs, where upon the insured qualifying as a chronically ill individual, the policy’s death benefit is used to make LTCI benefit payments to the insured. In the case of an annuity base plan, the death benefit is equivalent to the annuity’s account value, and LTCI benefit payments are made, gradually depleting this account value, with no surrender charge assessed. If the insured dies before the full death benefit is paid out under the ABR, the beneficiary receives the remainder of the death benefit. In addition, life versions of these types of plans normally pay a “residual death benefit” even when the base plan death benefit has in fact been exhausted. This is very appealing to those consumers who may have foregone the purchase of a standalone LTCI policy, due to the “use it or lose it” concern related to the fact that standalone LTCI policies typically pay back nothing upon death or surrender.

The addition of the EBR is the main difference between an LTCI Rider and a linked-benefit plan. Once the death benefit of the base policy has been exhausted, the EBR then comes into play. The EBR is often called the “independent benefit”. The insurer continues to make LTC benefit payments for the number of years specified under the EBR, even though the death benefit has been exhausted. This assumes, of course, that the insured still meets the definition of a chronically ill individual.

Thus, linked-benefit plans go beyond just accelerating the policy’s death benefit, providing truly independent LTCI coverage for a specified period of time.

Companies selling linked-benefit plans must comply with the same requirements outlined above for LTC ABRs and more, because they are not exempted from any sections of the NAIC LTCI Model Act and Regulation. This includes the required offering of an inflation benefit and an LTCI non-forfeiture benefit.

A. NAIC Long Term Care Insurance Model Regulation 641 and Model Act 640

LTC accelerated benefit riders, life/LTCI and annuity LTCI linked-benefit plans are governed by certain state regulations pertaining to long term care insurance. A majority of states have adopted the NAIC Long Term Care Insurance Model Act (640) and Model Regulation (641). The models include provisions that allow LTCI benefits funded through life and annuity policies. In some states, approval is needed through both the state’s life and health insurance departments, as the riders are considered long term care insurance.

Insurers offering long term care accelerated benefit riders on life contracts, life/LTCI linked-benefit and annuity/LTCI linked-benefit plans need to comply with the NAIC

Long Term Care Insurance Model Act and Regulation in the states where they have been adopted.

There are a minority of states that have not adopted the NAIC Long Term Care Insurance Model Regulation in a uniform manner. Some of these states do not yet have their own regulations regarding the above provisions for ABRs and independent LTC benefits, and in the meantime some departments of insurance have established some rules despite the lack of clarity as to whether existing regulations apply to these products. Some states may have adopted only portions of the model regulation, and/or may have issued their own bulletins and administrative rulings.

Benefit Triggers

Section 29 of the NAIC Long-Term Care Insurance Model Regulation includes standards for benefit triggers. Eligibility for payment of long-term care benefits shall not be more restrictive than requiring either a deficiency in the insured's ability to perform not more than three of the activities of daily living, or the presence of cognitive impairment. Activities of daily living shall include at least:

- Bathing
- Continence
- Dressing
- Eating
- Toileting
- Transferring

Insurers may use activities of daily living to trigger covered benefits in addition to the five listed above, as long as they are defined in the policy. In practice, most insurers require only two ADLs to be met or the cognitive impairment definition.

The determination of a deficiency shall not be more restrictive than requiring the hands-on assistance of another person to perform the prescribed activities of daily living, or if the deficiency is due to cognitive impairment, supervision or verbal cueing by another person is needed in order to protect the insured or others.

Assessments of activities of daily living and cognitive impairment must be performed by licensed or certified professionals, such as physicians, nurses or social workers. Long-term care insurance policies must include a description of the process for appealing and resolving benefit determinations. More details are provided in Section 30 of the model regulation. The NAIC Model Regulation also states that the term "Chronically ill individual" has the meaning prescribed for this term by section 7702B(c)(2) of the Internal Revenue Code of 1986 as amended.

Below are some examples of other provisions found in NAIC Model Regulation 641 that typically influence the design of LTC riders and linked-benefit plans:

- Renewal provisions must be either guaranteed renewable or noncancellable.

- Allows for certain exclusions of coverage such as pre-existing conditions, mental or nervous disorders (but Alzheimer's may not be excluded), alcoholism and drug addiction, and conditions arising out of war, service in the armed forces, participation in a felony, suicide and aviation. (List is not all inclusive)
- A Reinstatement provision is required, and the insurer must comply with certain rules to protect against the policy lapsing unintentionally.
- Disclosure of tax consequences is required: For life policies that accelerate a benefit for LTC, a disclosure statement is required at the time of application and the time of claim that receipt of the accelerated benefits may be taxable, and that assistance should be sought from a tax advisor. However, this does not apply to qualified long term care insurance contracts. Qualified LTCI contracts must contain a disclosure statement in both the policy and Outline of Coverage that the policy is intended to be a qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.
- Disclosure of rating practices is required.
- Prohibition against post-claims underwriting.
- If the policy provides for home health care benefits, the NAIC Model provides for minimum standards for home health and community care benefits. For example, certain types of benefits may not be excluded from coverage, such as adult day care services or personal care services provided by a home health aide.
- The NAIC Model has several requirements for policy disclosure, application forms and replacement coverage (see Administrative Considerations section).

There are certain sections in the NAIC LTCI Model Regulation where life insurance policies that accelerate benefits for long term care are exempted, and therefore certain rules will apply to only independent LTC benefits (the Extension of Benefits rider). For example, insurers offering life/LTCI or annuity/LTCI linked-benefit plans are required to offer inflation protection and a non-forfeiture benefit, whereas insurers offering only an LTCI accelerated benefit rider do not need to meet those requirements. (Note: other requirements applying only to independent benefits are listed in the Administrative Considerations section of this paper.)

- Inflation Protection

Insurers are required to offer an inflation rate not less than 5% compounded annually. The inflation benefit is typically optional and is available at issue only. The policyholder may reject the inflation protection at the time of sale. Inflation protection is not required to be offered during the acceleration period of a linked-benefit plan. However, most life/LTCI linked-benefit plans in the current marketplace offer the inflation option as a package on the policy as a whole, meaning that it applies during both the ABR and EBR payment periods. Inflation benefits are typically treated as independent benefits that do not affect the remaining base plan coverage. For an additional charge, the monthly benefit is increased by a specified percentage each year. Some life/LTCI linked-benefit plans offer the choice of a simple or compound inflation option. Some offer the

choice of inflation percentage (3%, 5%). The maximum monthly LTC benefit, and the lifetime maximum benefit less any LTC benefits already paid, are inflated. The LTC benefits must continue to increase even while the insured is on claim.

- Non-Forfeiture Benefits

Insurers are required to offer prescribed non-forfeiture benefit structures applicable upon policy lapse or upon certain rate increase actions taken by insurance companies. These are generally very small benefit levels, and are not very appealing to consumers of these products. In some cases, plans automatically include such nonforfeiture benefits. In other cases, they are optional benefits that are rarely elected by applicants.

B. Internal Revenue Code Section 7702B

Most insurers choose to construct their LTC accelerated benefit riders and linked-benefit plans under IRC Section 7702B, *Treatment of Qualified Long-Term Care Insurance*). These riders are qualified long term care insurance contracts under IRS Section 7702B. The LTC payments received are intended to be treated as accelerated death benefits for federal income tax purposes under Section 7702B, and are therefore not taxed, assuming the payments do not exceed the greater of actual qualified LTC expenses or the IRS maximum limits (known as “HIPAA per diem limits”). It should be noted that some insurers may choose to design an LTCI ABR that complies with Section 101(g) instead of Section 7702B, or that complies with both sections of the code.

Benefit Triggers

As noted earlier in the paper, Section 7702B(c)(2) provides the definition of a chronically ill individual. The insured must be unable to perform at least 2 ADLs for at least 90 days, meet the disability definition or the severe cognitive impairment definition. Insurers have generally used 2 ADLs or severe cognitive impairment as the qualification for receiving benefits under the LTCI rider or linked-benefit plan. The “at least 90 days” statement is of note, as it means that there is no requirement for the illness to be permanent for the insured to receive LTC benefits. Furthermore, the 90 day requirement is applicable to the licensed healthcare practitioner’s expectation of the duration of the impairment.

Ancillary Benefits

As described in Section 7702B, the term “qualified long-term care services” means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating and rehabilitative services, and maintenance or personal care services which (A) are required by a chronically ill individual, and (B) are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

The following benefits are typically provided in long term care accelerated benefit riders, life/LTCI and annuity/LTCI linked-benefit plans:

- Home health care
- Assisted living
- Nursing home
- Adult daycare
- Hospice services
- Care planning services
- Bed Reservation
- Respite Care

Other ancillary benefits such as caregiver training, personal care and alternative care are included in some products. Also, an International Coverage Benefit is typically provided on linked-benefit plans, but is not as commonly offered on life policies providing only an LTC accelerated benefit rider. The International Coverage benefit typically provides that if the insured is chronically ill and requires care while outside the U.S., he or she will still be eligible for some limited LTC benefits. Normally, the benefit only applies during the ABR period, and is not available during the EBR period. From the authors’ experience, this benefit will appeal to a small segment of the market that, at retirement, plans to live out their retirement years outside of the U.S.

C. Interstate Insurance Product Regulation Commission

The IIPRC has 10 Uniform Standards which apply to products with individual long term care benefits such as LTC riders or linked-benefit plans. The *Core Standards for Individual Long-Term Care Insurance Policies* was adopted by the IIPRC in December 2010. Any product filed with the IIPRC that is marketed as long term care insurance is subject to these standards. These Uniform Standards are available to be used in combination with state-approved individual life and annuity contracts, provided that the LTC rider (including application and rates) is filed and approved in accordance with the IIPRC’s standards.

The IIPRC’s Uniform LTC standards provide filing submission requirements, general form requirements, and policy provision requirements. We will highlight a few notable items below regarding policy provision requirements which should not be considered all-encompassing.

Similar to the NAIC Model Regulation, the IIPRC has an inflation protection requirement and a non-forfeiture benefit requirement that applies to independent LTC benefits. This means that the inflation protection and non-forfeiture benefit requirements apply to extension of benefit riders in linked-benefit plans, but do not apply to Long Term Care Accelerated Benefit riders. Regarding benefit triggers, the requirement on ADLs cannot be more restrictive than requiring either a deficiency in the ability to perform not more than two of the ADLs or the presence of cognitive impairment.

The Core Standards discuss additional benefit triggers for tax-qualified LTCI policies. The policy should provide benefits only for qualified long term care services and a plan of care is required. The policy should state that payment of benefits is conditioned on a determination of the insured's inability to perform activities of daily living for an expected period of at least 90 days due to a loss of functional capacity or to severe cognitive impairment.

The Core Standards also lay out several terms that need to be defined in the policy itself (e.g. "Activities of daily living", "Adult day care", "Assisted living care", "Chronically ill individual", "Cognitive impairment", "Qualified long-term care services" and more) and include a definition for each term. These definitions are actually the minimum requirements that insurers need to follow in creating their definitions; the definitions may not be less favorable than the IIPRC definitions.

For those policies that provide for home health care, the Core Standards discuss minimum standards for home health care. For example, the dollar amount of home health care coverage must be at least half of the nursing home benefits under the policy. Also discussed are guidelines to be followed for an incontestability provision and what is allowed regarding limitations and exclusions in the policy. Examples of permitted exclusions in the policy: alcoholism and drug addiction, suicide, and conditions arising from war, participation in a felony, active duty in the armed forces and aviation.

In regard to renewal provisions, the Core Standards state that the policy should not contain renewal provisions other than "guaranteed renewable" or "noncancellable".

The *Standards for Individual Long-Term Care Insurance Benefit Features*, adopted by the IIPRC in December 2010, must also be followed. These Uniform Standards apply to forms that include LTCI benefit features that are built into an individual long term care, life or disability insurance policy, or an individual annuity contract; or added to an individual long term care, life or disability insurance policy, or an individual annuity contract by rider. The Uniform Standards include general filing and disclosure requirements for riders, statement of variability information for all forms and what certain benefit provisions need to describe (e.g. additional benefit eligibility requirements, when benefits are payable, duration and amount of benefit, etc.).

In regard to the *Rate Filing Standards for Individual LTCI - Issue Age Rate Schedules Only*) and the *Rate Filing Standards for Individual LTCI - Modified Rate Schedules*, the following exception applies:

No specific rate standards apply to the following LTCI products:

1. Life insurance policies that permit payment of all or part of the death benefit when specified activities of daily living or cognitive impairment triggers are met and the payment of benefits is contingent upon receipt of long-term care services, and such payment does not exceed \$1.00 for \$1.00 of reduction in death benefits (for flexible premium adjustable life products, the death benefit may be one of the death benefit options described in the IIPRC standards for such products); and
2. Annuity contracts that provide for the waiver of any applicable surrender or withdrawal charges upon payment of all or part of the account value when specified activities of daily living or cognitive impairment triggers are met and the payment of benefits is contingent upon receipt of long-term care services, and such payment does not exceed \$1.00 for each \$1.00 of permanent reduction in the account value.

A translation of the above two exceptions: Basically, no rate standards apply to Long Term Care Accelerated Benefit riders, but the rate standards **do apply** to extension of benefit riders, which means they apply to linked-benefit plans.

The IIPRC has also produced the *Standards for Individual LTCI Advertising Material*, *Individual LTCI Application Standards*, *Standards for Individual LTCI Application Change Form*, *Individual LTCI Standards for the Outline of Coverage* and *Standards for Forms Required to be Used with an Individual LTCI application*. This last Uniform Standard discusses the LTC suitability forms (Personal Worksheet and Things Your Should Know Before You Buy LTCI), Potential Rate Increase Disclosure Form, Replacement Notice and HIPAA Medical Authorization.

D. HIPAA

Annuity or life insurance contracts with riders that are “qualified” under IRC Section 7702B must comply with HIPAA. Therefore, qualified LTCI accelerated benefit riders, life/LTCI linked-benefit and annuity/LTCI linked-benefit plans must comply with HIPAA.

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) was endorsed by the U.S. Congress. The HIPAA Privacy Rule, also called the Standards for Privacy of Individually Identifiable Health Information, provided the first nationally-recognizable regulations for the use/disclosure of an individual’s health information. Essentially, the Privacy Rule defines how covered entities use individually-identifiable health information or the PHI (Personal Health Information). ‘Covered entities’ is a term often used in HIPAA-compliant guidelines. This definition of a covered entity is specified by [45 CFR § 160.102] of the Privacy Rule. A covered entity can be a:

- Health plan
- Healthcare clearinghouse
- Healthcare provider

Overview of the Privacy Rule

- Gives patients control over the use of their health information
- Defines boundaries for the use/disclosure of health records by covered entities
- Establishes national-level standards that healthcare providers must comply with
- Helps to limit the use of PHI and minimizes chances of its inappropriate disclosure
- Strictly investigates compliance-related issues and holds violators accountable with civil or criminal penalties for violating the privacy of an individual's PHI
- Supports the cause of disclosing PHI without individual consent for individual healthcare needs, public benefit and national interests

HIPAA required the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. Therefore, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The Privacy Rule, or *Standards for Privacy of Individually Identifiable Health Information*, establishes national standards for the protection of certain health information. The *Security Standards for the Protection of Electronic Protected Health Information* (the Security Rule) establish a national set of security standards for protecting certain health information that is held or transferred in electronic form. The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that covered entities must put in place to secure individuals' "electronic protected health information" (e-PHI). Within HHS, the Office for Civil Rights (OCR) has responsibility for enforcing the Privacy and Security Rules with voluntary compliance activities and civil money penalties.

Some companies have found that complying with the privacy standards of HIPAA involves some extensive modifications to their systems and procedures.

II. Charges for the Benefits

Life Insurance:

Charges for the LTCI benefit on a life insurance plan could be based on a base plan cost of insurance (COI) set-forward (where a higher age is used to determine combined life and LTCI charges), a yearly renewable term charge (YRT), a level charge per \$1000 of net amount at risk (NAR), or other variations. These amounts may vary based on issue age, sex, and/or underwriting class. In some cases, LTCI charges are guaranteed at issue ("non-cancelable"), while in others the carrier reserves the right to increase charges from the current level up to a specified guaranteed maximum ("guaranteed

renewable” with a rate cap). A non-cancelable provision of course increases the risk profile of the rider for the insurance company.

Charges may be payable to age 95, to age 100, or for the life of the base contract. Also, marital discounts are sometimes offered.

Charges for accelerated benefit riders are typically on a YRT basis. Such charges largely eliminate persistency risk and interest rate risk. However, several states now require level charges. We are aware of at least five states (Florida, North Carolina, Ohio, Colorado, and Hawaii) that require level “premiums” for LTCI benefits.

Charges for the extension of benefit riders and inflation protection riders are always based on level charges. Level charges create persistency risk and interest rate risk and also bring up questions regarding reserving levels. However, the NAIC Long-Term Care Model Regulation includes a provision indicating that LTCI premiums may not be increased beyond age 65.

Until recently in the life/LTCI linked-benefit marketplace, EBR charges were on a unisex basis. The use of unisex rates, however, creates distribution by sex risk for the company. Based on the authors’ experience, the tide seems to have turned toward using sex-distinct pricing on both the ABR and the EBRs.

Insurers may choose to offer a marital discount. If an individual is married, he or she has a built-in informal caregiver in the form of the spouse, who can assist the individual if they are in need of care. Therefore, the “married” status generally reduces formal LTC claims costs.

Annuities

There are three general policy designs used with annuity/LTC linked-benefits. The first is the “tail design”, where benefits are first paid from the account value until it is depleted, and then independent extension benefits are paid thereafter in the tail. The level of monthly payments are generally defined as a percentage of the account value that exists when a claim first occurs.

A second variation is the coinsurance design. Under that approach, a portion of each monthly payment comes from the account value and the remainder is paid directly by the insurance company without reducing account values further. As for the first design, once the account value is depleted, benefits are continued in the tail so long as the insured is chronically ill and maximum lifetime benefits have not been reached.

The third design is often referred to as the pool approach, where the lifetime maximum benefits and monthly benefits are defined in terms of an amount defined at issue and frozen. This might be expressed as a multiple of the single premium for the policy. Benefit payments normally would come first from the account value, and once that is depleted, the remainder is paid directly by the insurance company.

The charge for the LTCI rider is usually expressed as a basis point charge against the current annuity account value, or in the case of the pool design, a cost of insurance rate times the net amount at risk. (Note that the excess of the maximum LTC pool amount over the account value defines a net amount at risk. The portion of the benefit payment that is an accelerated benefit increases as the account value grows, while the independent benefit portion decreases. Benefit payments reduce the maximum LTC pool and account value on a dollar-for-dollar basis.) The charge is typically deducted from the account value monthly.

The rate schedule may be an attained age scale or vary by issue age; however, it should be noted that the LTCI model regulation stipulates that rates must be level for ages 65 and older. One view of the use of a constant basis point charge applied to an increasing account value is that this represents a series of level charges stacked together, just as the long term care benefits represent layers of LTC benefits generated by the year-by-year account value growth.

The charge schedule can be fully guaranteed or have a current and guaranteed maximum scale. A key advantage to having current and guaranteed maximum scales is the ability to increase rider charges in the future if experience is unfavorable. The producer might have to run illustrations on both the current and guaranteed scales, which can make for a more difficult sale. Changes in the rate schedule require notification to the state insurance departments, with an actuarial memorandum justifying the change, at least 30 days prior to notice to contract holders.

As is the case for life insurers, annuity insurers may also choose to offer a marital discount. In the current annuity/LTCI linked-benefit marketplace, LTCI rider charges are on a unisex basis. The use of unisex rates, however, creates distribution by sex risk for the company, since actual claims costs are higher for females than males. A marital discount is a means to reduce distribution by sex risk. If all of a company's combo business were all married couples, this would, in effect, eliminate the distribution-by-sex risk. So it may make sense for a company to offer a marital discount, in order to reduce their risk. As an alternative, companies may want to consider the use of sex-distinct charges for the rider, mirroring the changes seen in the stand-alone LTCI market as most of those carriers have recently moved to premiums varying by sex.

III. LTCI Benefit Payment Approaches

There are three primary approaches to benefit payments: a "reimbursement" basis, an "indemnity" basis, and a "cash" or "disability" basis. Any of these may be used with an LTCI rider, a life/LTCI linked-benefit plan or an annuity/LTCI linked-benefit plan.

A "reimbursement" basis benefit reimburses actual expenses incurred by the insured for covered services, typically up to a daily or monthly cap. Because benefit payments are limited to the actual expenses incurred, this structure is expected to produce lower expected benefit payments than the other two structures. However, this comes at the

cost of a relatively intensive claims adjudication process, because itemized bills must be received and tracked in order to administer claim payments.

An “indemnity” basis benefit differs from a reimbursement basis benefit in that, rather than reimbursing actual expenses incurred, the benefit pays a specified amount, typically per day or per month. However, like a reimbursement benefit, formal care for which charges are assessed must be received by the insured in order for benefits to be payable. The insurance company still requires documentation of care provided under an indemnity plan. An indemnity benefit payment structure can create a risk of over-insurance, since payments can be made in excess of expenses actually incurred by the insured. This increases the cost of indemnity plan by 10% to 20% above the cost of an expense reimbursement model based on the authors’ views.

Finally, a “cash” or “disability” basis makes fixed daily or monthly payments as long as the criteria for disability (such as deficiencies in two out of six ADLs) are met. These payments are fixed, indemnity payments that are made regardless of whether or not the insured receives any formal care. Unlike the first two approaches, the insurance company does not require documentation of care received. This design is much more expensive than the prior two designs, and in particular is 60% to 80% more costly than the reimbursement design under the authors’ views.

The following chart summarizes the pros and cons of the reimbursement, indemnity, and disability approaches.

Payment Structure	Pros	Cons
Reimbursement	<ul style="list-style-type: none"> • Expected to produce lower benefit payments than the indemnity and disability approaches because payment is limited to actual expenses incurred • Due to the expected lower benefit payments, the cost of the rider is thereby reduced • No over-insurance risk • Less expensive than indemnity and disability approaches 	<ul style="list-style-type: none"> • Relatively intensive claims adjudication process which likely results in higher claims adjudication costs • Not as appealing to agents and insureds from a marketing standpoint, ignoring the premium differentials
Indemnity	<ul style="list-style-type: none"> • Simpler design than reimbursement structure • Less expensive than disability approach • Less complicated to administer than reimbursement structure • Less intensive claims adjudication process than reimbursement 	<ul style="list-style-type: none"> • More expensive than reimbursement structure • Over-insurance risk • Taxable LTCI benefits may be triggered if they exceed expenses incurred and HIPAA limits

Payment Structure	Pros	Cons
	structure which likely results in less claim adjudication costs.	
Disability	<ul style="list-style-type: none"> • Simplest structure in that it only requires that ADL or cognitive impairment triggers be met, with no formal caregiver requirements (other than those that might be imposed by a plan of care) 	<ul style="list-style-type: none"> • Most expensive structure • Significant over insurance risk • Taxable LTC benefits may be triggered if they exceed expenses incurred and HIPAA limits

IV. Policyholder Taxation

The Pension Protection Act of 2006 (PPA) further opened the door for LTCI riders and linked-benefit plans. The PPA clarified that charges for tax-qualified or non-qualified LTCI riders on life policies are deemed distributions (retroactive to the enactment of HIPAA in 1996), but for tax qualified riders those distributions beginning in 2010 will not be taxable but will reduce basis in the contract. The law also allows for 1035 exchanges into linked-benefit plans.

The PPA provides for favorable treatment of tax-qualified LTCI riders attached to non-qualified annuities, for tax years beginning after December 31, 2009. A key provision is that LTCI pay-outs, even if they are accompanied by a commensurate reduction in account values in the base plans, are tax-free LTCI benefits. However, legislative history suggests that for this to be true, a meaningful amount at risk for the insurance company needs to be present. This is one of the key factors to consider among the design variations discussed above. Among other things, PPA also clearly states that the charges deducted from the account value to pay for the rider are considered to be non-taxable distributions from the annuity contract; however, such deductions also reduce the investment basis in the contract.

The PPA is not as clear regarding the effect that LTC benefits have on the contract's basis. A number of companies have taken the position that the basis is not reduced by the payment of LTC benefits from the contract's account value. Under this interpretation the taxable gain in the contract may be significantly reduced, in some cases to zero, if it is used to provide LTC benefits. In making this interpretation, companies note that the PPA states that the portion of the contract providing LTCI coverage is a separate contract. Section 7702B already provides that amounts received under a qualified LTC contract are excludable from income, subject to annually adjusted limits. Further, as stated in the Technical Explanation of the act by the Joint Committee on Taxation,

“The provision provides that, except as otherwise provided in regulations, for federal tax purposes, in the case of a long-term care insurance contract (whether

or not qualified) provided by a rider on or as part of a life insurance contract or an annuity contract, the portion of the contract providing long-term care insurance coverage is treated as a separate contract. The term “portion” means only the terms and benefits under a life insurance contract or annuity contract that are in addition to the terms and benefits under the contract without regard to long-term care coverage. As a result, if the applicable requirements are met by the long-term care portion of the contract, amounts received under the contract as provided by the rider are treated in the same manner as long-term care insurance benefits, whether or not the payment of such amounts causes a reduction in the life insurance contract’s death benefit or cash surrender value or in the annuity contract’s cash value.”

Finally, it is argued that if the intention was to treat the benefit payments as distributions of basis first, the PPA would have stated this explicitly as it does with regard to charges deducted from the account value. Nonetheless, the Internal Revenue Service and Treasury have not provided complete guidance on this subject, even after a formal request for guidance via an ACLI paper submitted to those bodies in 2009.

It should also be noted that although premiums for stand-alone qualified LTCI policies may qualify as a deductible medical expense for tax purposes, subject to HIPAA prescribed limits that are updated annually, that treatment does not extend to LTCI riders to life or annuity products.

V. Impact on Policy Pricing – Anti-Selection, Mortality, Policy Persistency and Premium Persistency Issues

This is covered in Sections XI, XII, and XIII below which summarize the survey results, as well as in Appendix II. The most significant implications for pricing are present for linked-benefit life or annuity products.

VI. Impact on Reinsurance Pricing and Administration

This is covered in Sections XI, XII, and XIII below which summarize the survey results, as well as in Appendix II. Limited commentary is also provided in Sections XIV, XV, and XVI. It should be noted that many of the earlier comments on accelerated benefit riders for chronic illness apply to accelerated benefit riders for LTCI.

VII. Underwriting Considerations

Underwriting an LTCI rider on a life policy typically makes use of one or more of the following tools: 1) an application, which can be either supplemental to an existing life application or can be incorporated into it (depending on whether the rider is optional or not), 2) a phone interview, 3) medical records or attending physician statement, 4) a

cognitive screen, 5) a prescription drug screen and 6) a face-to-face exam. The tools that are used at each age, in conjunction with the decisions that are made based on the information discovered, will determine the selection factors that are used in pricing.

There are two prevailing approaches to underwriting for LTCI riders when attached to a life insurance policy, each with some trade-offs between anti-selection risk and underwriting cost.

The first approach is to supplement an existing life insurance application with a supplemental LTCI application, where the supplemental application asks about conditions that may be of particular concern for LTCI. This approach would typically be used when the LTCI rider is optional at the time of purchase. The additional LTCI application questions might relate to existence of Activities of Daily Living (ADL) impairments, past use of nursing homes or home health care, and specific age-related conditions which were not listed in the life application (e.g., Alzheimer's, arthritis, Parkinson's). These questions would be designed to discover information about conditions that might lead to a long disabled life (the risk for LTCI), rather than to an early death. Attending physicians' statements, paramedical exams, and blood work-ups are typically requested on the life policy, depending on the person's age at issue and life face amount. If an LTCI rider is being added, the criteria used to determine when these tools are used could be changed (e.g., getting an Attending Physician's Statement (APS) might be requested for younger ages), and some screening tools could be added (e.g., cognitive and/or drug screens and face-to-face exams).

Under this first approach, the pricing selection factors that would be applied for a life policy with a supplemental LTCI application would depend on:

- the life and the supplemental LTCI application questions (how extensive and thorough they are)
- whether cognitive testing is done, and at what ages
- whether phone interviews or medical records are obtained, and for what ages
- whether a face-to-face exam is used, and for what ages, and
- whether a drug screen is used to verify the accuracy of the application.

The second approach is to use a combined application for both the life insurance and the LTCI rider sale. This approach would typically be used when the LTCI benefits (or at least accelerated benefits) are a required component of the total coverage, and usually on single premium plans. While this approach could technically be used in conjunction with "full" underwriting, we have most frequently seen it used with simplified underwriting. With simplified underwriting, the application is shortened to a one- or two-page list of knock-out questions. For those who successfully answer all of the knock-out questions, supplemental tools may be used to expand on the questions in the applications and to gather additional information. These tools generally include a prescription drug screen and a policyholder phone interview (which includes a cognitive screen). An APS or a face-to-face exam could be ordered at the underwriter's discretion, if any concerns remain after the phone interview.

Under the second approach, the pricing selection factors that would be applied would depend on:

- the application questions (how extensive and thorough they are)
- whether cognitive testing is done, and at what ages
- how thorough the phone interview is, and
- whether a drug screen is used to verify the accuracy of the application and the phone interview.

There are several third party administrators who are able to assist with either performing the LTCI portion of full underwriting or doing the phone history interviews.

When underwriting an annuity/LTCI linked-benefit plan, there may be somewhat less medical information gathered versus life/LTCI linked-benefit plans. However, many of the same tools are used.

VIII. Base Product Platforms

Life Insurance

LTCI accelerated benefit riders and Life/LTCI linked-benefit plans are offered on a wide variety of life insurance plans, including universal life (single and flexible premiums), indexed universal life, variable universal life and whole life.

Annuities

In general, insurers have not offered just the LTCI accelerated benefit rider on annuities without the EBR. For annuity/LTCI linked-benefit plans, the base plan is normally a single premium fixed deferred annuity, although one insurer has offered a variable annuity as the base plan.

IX. Residual Death Benefits

Life Insurance

A residual death benefit feature is commonly included in both LTCI accelerated benefit riders and life/LTCI linked-benefit plans, although it is not a legal requirement. Its purpose is to guarantee that some life insurance coverage is available for the life beneficiary even if contract values have been drained due to LTC needs. A typical residual death benefit may be equal to a certain percentage of the initial death benefit, such as 5% or 10%. Some companies also choose to cap the residual death benefit at a certain dollar amount. The amount payable is normally adjusted for loans and partial withdrawals. The death benefit payable is the greater of the residual death benefit or the policy death benefit.

Annuities

The residual death benefit concept has not been applied to annuity/LTCI linked-benefit plans.

- X. Administrative Considerations: New Business and Inforce Policy Administration, Claims Administration, Outsourcing Considerations

New Business and Inforce Policy Administration

Requirements that apply to both LTCI Accelerated Benefits and Independent LTCI Benefits:

Both the NAIC Long Term Care Insurance Model Act (640) and the NAIC Long Term Care Insurance Model Regulation (641) dictates a number of key requirements that apply to both LTC accelerated benefit riders and independent LTC riders (part of the “linked-benefit” product offering), regardless of whether it is a life or annuity base plan.

- New business requirements:
 - Outline of Coverage form
 - Disclosure provisions required in the policy
 - Requirements for application forms and replacement coverage
 - Filing of advertising
 - Long Term Care Personal Worksheet (a suitability form: see Model Regulation 641 section 23, *Standards for Marketing*)
 - Long Term Care Insurance Potential Rate Increase Disclosure Form
 - Requirements for policy summaries and illustrations
 - Filing requirements
 - Producer training requirements
 - Establish marketing procedures and agent training requirements
- Inforce requirements:
 - The NAIC LTCI Model Regulation also instructs insurers regarding annual reporting requirements to the commissioner using the following forms:
 - LTC Replacement and Lapse Reporting Form
 - LTC Claims Denial Reporting Form
 - Rescission Reporting Form
 - Also, the regulation discusses a monthly report that should be provided to policyholders during the time a policy is on claim.

Requirements that apply only to independent LTCI benefits (not LTCI accelerated benefits):

As mentioned previously, there are a number of sections in the NAIC LTCI Model Regulation where policies that accelerate benefits for long term care are exempted, and therefore certain rules will apply to only independent LTCI benefits. That means that insurers offering life/LTCI or annuity/LTCI linked-benefit plans will need to comply with the following sections of the regulation:

- Suitability (Regulation 641, section 24): Among other things, includes a requirement for the new business form “Things You Should Know Before You Buy LTCI” and the development of suitability standards along with agent training on the topic.
- Loss-ratio (Regulation 641, section 19)
- Inflation Protection Benefit (Regulation 641, section 13)
- Non-Forfeiture Benefit (Regulation 641, section 28)
- Shopper’s Guide (Regulation 641, section 32)
- Availability of New Services or Providers (Regulation 641, section 26)
- Right to reduce coverage and lower premiums (Regulation 641, section 27)

It is worth mentioning that the IIPRC requires an annual LTC rate certification to be submitted for LTCI forms that were approved through the IIPRC. The IIPRC needs a statement that the premium rate schedule continues to be sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated. An actuarial memo that complies with Actuarial Standard of Practice (ASOP) 18 is necessary every three years. It should include a detailed explanation of the data sources and review performed and a complete description of experience assumptions and their relationship to the initial pricing assumptions.

Administrative Considerations regarding the International Coverage Benefit

Per the experiences of the authors, some companies do not wish to get involved in the administrative complications an international coverage benefit causes the company. For example, most companies find it hard to validate ADLs because they don’t have a network of nurses internationally. Some companies therefore limit the international coverage benefit to nursing home care only. However, it is also more difficult to verify that the insured is living in a facility when the insured is not in the U.S.

Claims Administration

Specialized claims administration capabilities are generally required for LTCI with complexity dependent on plan structure. With accelerated benefits, the value of the LTCI benefits is greatly reduced, particularly if the longevity outlook of the claimant is significantly impaired. Thus, the costs of complex claims-support procedures may not be justified in some situations.

An expense reimbursement model caps benefits equal to expenses and requires not only monitoring of claimants, but tracking of bills and bill amounts. An indemnity model requires formal care, but pays a predefined amount. This structure, however, still requires proof of care for every period. A disability model is based on disability only, with a fixed benefit but no formal care requirement. Tax qualified status requires certification by a health care professional that disability is expected to last at least 90 days, and annual recertification thereafter.

In the case of independent LTCI benefits that do not reduce base plan benefits, if the insurer does not have experience in LTCI claims issues, there are outsourcing services that may be able to provide support in these areas. The effective integration of these functions with the direct writer’s base policy claims management functions can be difficult to coordinate.

Claims Reporting Requirements

Section 6050U of the Pension Protection Act discusses claims reporting requirements. Insurance companies are required to report claims to the IRS. Items that should be included are charges against the contract for the calendar year, the amount of the reduction in the investment in the contract because of the charges, and the name, address and taxpayer identification number of the individual contract holder.

Insurance companies are also required to provide individual contract holders with a written statement on the claims, before January 31st of the year following the calendar year in which the claims were paid.

Please see Section 6050U of the Pension Protection Act for full details.

XI. Executive Summary of Direct Writer Survey Pertaining to Long Term Care Insurance Riders

Seven of the 34 survey participants responded to questions relative to Life/LTCI accelerated benefit riders. One of the seven provided responses for two Life/LTCI ABR plans, so a total of eight plans were reported.

Six of the eight plans are recurring premium plans and two are single premium plans. The table below shows total sales by calendar year reported by survey participants, as well as the average and median sales per plan.

Appendix II Figure 53: First Year Premium – Life/LTCI ABR Plans

Calendar Year	Number of Plans	Life/LTCI ABR Sales (\$ Millions First Year Premium)		
		Total	Average	Median
2011	6	\$108.2	\$18.0	\$18.7

Calendar Year	Number of Plans	Life/LTCI ABR Sales (\$ Millions First Year Premium)		
		Total	Average	Median
2012	7	\$137.9	\$19.7	\$18.4
2013	8	\$239.4	\$29.9	\$23.4

Term periods of approximately two, three, and four years were reported by participants, as well as other term periods. It was noted that under many plans the ABR term periods is indefinite and continues until the total face amount is paid out.

Appendix II Figure 54: First Year Premium Distribution by ABR Term Period – Life/LTCI ABR Plans

ABR Term Period	Distribution of Sales
Approximately 2 years	52.7%
Approximately 3 years	18.9%
Approximately 4 years	20.6%
Other	7.8%

The table below shows the distribution of life/LTCI ABR sales for calendar year 2013 by issue age range, as reported by seven survey participants for eight plans. The average issue age is 56.

Appendix II Figure 56: First Year Premium Distribution by Issue Age Range – Life/LTCI ABR Plans

Issue Age Range	Distribution of Sales
< 30	1.2%
30 – 34	2.1%
35 – 39	3.5%
40 – 44	7.1%
45 – 49	10.7%
50 – 54	17.5%
55 – 59	19.2%
60 – 64	16.1%
65 – 69	15.5%
70 – 74	4.7%
75 – 79	2.5%
80+	0.1%

Of the eight life/LTCI ABR plans, the governing tax law is Section 7702B of the Internal Revenue Code (IRC) for six plans. The remaining two plans were reported as governed under Section 101(g) of the IRC.

Life/LTCI accelerated benefit riders are offered on a variety of base life insurance product chassis. Half of the life/LTCI ABR plans are offered on multiple base product chassis.

The most popular chassis reported by survey participants is a universal life chassis (6), followed by indexed UL (4), variable life (3), and whole life insurance (2). None are offered with a joint life LTC option.

Five of the eight plans use the indemnity approach. Under this approach, LTC expenses are reimbursed based on a specified amount per day or month, provided billable covered services are received. Two plans use a disability/cash approach. The final plan uses an expense reimbursement approach.

Survey participants were asked if the maximum lifetime LTC benefit is linked to the life insurance face amount, or chosen independently by the applicant. For five of the eight life/LTCI ABR plans, the maximum lifetime LTC benefit is chosen independently by the applicant. For the remaining three plans, the maximum lifetime LTC benefit is linked to the life insurance face amount.

The basis of first year commissions on life/LTCI ABR riders is incremental commissionable target premiums for six of the plans included in the survey. For two additional plans, the basis is a percentage of target rider charges/premiums. In all cases, the first year commission percentages are the same as those applicable to the base plan.

The most common underwriting tools used with life/LTCI ABR plans are medical records or attending physician's statements, prescription drug screens, applications that are incorporated into the life insurance application, and cognitive screens. The table below shows a summary of the number of life/LTCI ABR plans that use various underwriting tools.

Appendix II Figure 69: Use of Underwriting Tools

Underwriting Tool	Number of Plans That Use the Tool
Medical records or Attending Physician's Statement	8
Prescription Drug Screen	7
Application that is Supplemental to an Existing Life Application	5
Cognitive Screen	5
Pre-screening Questionnaire	3
Application that is Incorporated into a Life Application	3
Phone Interview	3

A variety of cost structures were reported by survey participants for life/LTCI ABR plans. A yearly renewable term (YRT) charge based on per \$1,000 of net amount at risk (NAR) was reported for four life/LTCI ABR plans for the majority of states. For those four plans, there are a number of states where the charges are level per \$1,000 of

NAR or level per \$1,000 of face amount, but the states in which level charges are used vary somewhat among the four companies.

Guarantees included with the accelerated benefit rider are consistent among survey participants. All eight plans have current charge/premium scales that are accompanied by a maximum guaranteed charge/premium.

For six of the eight life/LTCI ABR plans, the incidence of claims from 2010 through 2013 relative to that assumed in pricing was close to or better than expected, usually attributed to the frequency of claims being lower than expected.

None of the life/LTCI ABR plans are reinsured, for a variety of reasons.

Five comments were received regarding the implications of reinsuring the base life plan, but not the life/LTCI ABR. One implication reported is that as the death benefit is drawn down, the net amount at risk decreases. When determining the reinsurance amount this factor needs to be considered. A second comment indicated that if the death benefits that are accelerated exceed the cash value and the policy lapses before the insured dies, then the company would not receive reimbursement of the difference from the reinsurer. Two additional comments noted that the implication of reinsuring the base life plan, but not the life/LTCI ABR is that there would be timing differences in the benefit cash flows relative to the reinsurance cash flows.

The impact of including the LTC accelerated benefit on factors such as policyholder optionality/anti-selection, mortality, policy persistency, and premium persistency was reported for five life/LTCI ABR plans. In general, the majority of responses indicated that there is no impact of including the LTC accelerated benefit on these factors.

For five plans, it was reported that profits are enhanced by including the LTC ABR. For the remaining three plans, it was reported that there was no material impact on profits by inclusion of the LTC ABR.

Two of the eight life/LTCI ABR plans factor in the preservation of overall mortality, such that disabled life deaths, plus active life deaths equals the original deaths for life only. Five of the remaining six plans do not factor in the preservation of overall mortality. No response was received for the final plan. This was surprising to the authors, and it suggests that there may be higher profits embedded in this business than companies are quantifying, since those lives that are not on claim are healthier than overall averages among the entire insured population.

LTC benefit utilization on the life/LTCI ABR plan is assumed to be lower than that assumed on standalone LTC plans for six of the eight plans.

The responses were evenly split between two pricing methods used to price the life/LTCI ABR. Four of the eight plans are priced based on an integrated approach with the life plan and LTC ABR combined. The remaining four plans are priced with

the ABR priced independently from the life benefit. The survey did not explore how these companies captured the interactions between rider benefits and remaining life insurance benefits.

Additional active life reserves for the life/LTCI ABR (when the insured is not receiving accelerated benefits) are typically held. Various calculation methods were reported for these plans.

Disabled life/claim reserves are also common for the life/LTCI ABR when the insured is receiving accelerated benefits. For the majority of the plans, a separate additional reserve is calculated using standard LTC reserving methods.

Similar to the frequency of holding additional reserves, it is common for additional target surplus to be held for life/LTCI accelerated benefit riders. Specifics are included in Appendix II.

Various opinions are held by survey participants regarding which agent licenses are required to sell the life/LTCI ABR. For two of the eight plans, it was reported that only a life license is required. For two additional plans, a life and health license is required for the agent to sell this benefit. For another two plans, it was reported that agents are required to have a life and LTC license to sell the life/LTCI ABR. For one of the final two plans, a life, health, and LTC licenses are thought to be required. Relative to the final plan, agents are required to have a life and health license, and the requirement of a LTC license varies by state. Responses regarding the applicability of long term care insurance training requirements to the life/LTCI ABR were evenly split.

This diversity of views was surprising. Part of this may be explained by different views in different states, but it is likely that the lack of clarity of regulations and their applicability to these riders is part of the explanation.

Significant filing variations were reported for six of the eight life/LTCI ABR plans. The most filing variations were reported for the state of New York (5). Specifics are in Appendix II.

XII. Executive Summary of Direct Writer Survey Pertaining to Life/LTCI Linked-Benefit Plan

Seven of the 34 survey participants responded to questions relative to Life/LTCI linked-benefit plans. One of the seven provided responses for more than one Life/LTCI linked-benefit plan. A total of eight plans were reported for Life/LTCI linked-benefits.

Total first year premium was reported by six survey participants relative to life/LTCI linked-benefit plans. The six participants reported sales for seven plans. Four of the plans are single premium, two are recurring premium plans, and one plan did not provide a response to this question. Total first year premium refers to the total actual

dollars of first year premium received. Total premiums for three of the seven plans equaled nearly \$341 million in calendar year 2012. The total premium reported for seven plans equaled about \$805 million in calendar year 2013. The table below shows total sales by calendar year reported by survey participants, as well as the average and median sales per plan. Based on our knowledge, the survey results are not representative of total industry sales which are substantially higher than that shown.

Appendix II Figure 79: First Year Premium – Life/LTCI Linked-Benefit Plans

Calendar Year	Number of Plans	Life/LTCI Linked-Benefit Plan Sales (\$ millions)		
		Total	Average	Median
2012	3	\$340.8	\$113.6	\$120.7
2013	7	\$804.9	\$115.0	\$72.5

Various other breakdowns of sales are provided in Appendix II.

For all seven life/LTCI linked-benefit plans responding to Part II of the survey, the governing tax law is Section 7702B of the Internal Revenue Code (IRC). One of the seven plans is also governed under Section 101(g) of the IRC.

The majority of survey participants reported that life/LTCI linked-benefit riders are attached to single premium products. Four of the seven survey plans are attached to single premium products only. One additional plan is attached to both single premium and recurring premium products. The final two plans are attached to recurring premium products, but it was noted that one of the two plans may be funded by various premium patterns, including a single premium.

For three of the plans, a single premium in excess of \$1,000 per unit of face amount is allowed (note that this can occur at older ages and richer benefit configurations because of the cost of the LTCI riders, coupled with high life premiums). Three additional responses indicated that a single premium in excess of \$1,000 per unit of face amount is not allowed.

Five of the seven plans use the expense reimbursement approach. Two plans use a disability/cash approach. Here as well, it would appear that the desire to keep the cost of the coverage down is consistent with the use of the lower cost expense reimbursement model. All caps are on a monthly basis.

Survey participants were asked if the maximum lifetime LTC benefit is linked to the life insurance face amount, or chosen independently by the applicant. For all seven life/LTCI linked-benefit plans, the maximum lifetime LTC benefit is linked to the life insurance face amount.

For most plans, the elimination period is 90 calendar days that do not need to be consecutive, and the elimination period is satisfied once in a lifetime.

Four of the seven plans include a 100% return of premium (ROP) benefit with the life/LTCI linked-benefit plan. The fifth plan includes a return of premium benefit equal to 90% in the first two years, and 100% in years three and thereafter. Two ROP options are available on the sixth life/LTCI linked-benefit plan. The first option is equal to 80% of the premium and the second option is equal to 80% grading to 100%. The final plan does not include an ROP benefit. The ROP provision has been very popular in the marketing of these products, but it comes with some risks to the company in terms of potential lapse activity, and it also creates some additional reserve and capital requirements. As such, several companies have developed newer versions of these plans that do not allow the full return of 100% of the premium in early durations.

Nearly every life/LTCI linked-benefit plan reported in the survey offers different inflation protection benefit options. No inflation protection benefits are available on one of the seven plans, interestingly. Five plans offer multiple inflation protection options.

Appendix II Figure 92: Inflation Protection Benefits

Inflation Protection Benefit	Number of Plans that Offer
3% Simple Interest	4
5% Simple Interest	2
3% Compound Interest	2
5% Compound Interest	6

All seven life/LTCI linked-benefit plans include the nonforfeiture option in the base coverage, rather than offer an optional benefit.

Various first year commission structures on life/LTCI linked-benefits were reported by survey participants. For most plans, the base plan and rider compensation are intertwined, with separable commission target premiums defined for the base plan and riders.

Appendix II shows a summary of the number of life/LTCI linked-benefit plans that use various underwriting tools. Because these policies are primarily single premium, there is usually less extensive underwriting than that used for stand-alone life insurance, stand-alone LTCI, or even life policies with LTCI ABR riders. Further, the major carriers often emphasize their ability to underwrite these products in relative short time frames (e.g., 3 to 7 days).

Four of the seven life/LTCI linked-benefit plans use in-house underwriters to underwrite the benefit. Two of the four also use a third party telephone vendor. The final three plans use a third party underwriter. In particular, because several of these carriers are relatively new to LTCI underwriting, they have brought in third party expertise to assist in this area. In addition, these special vendors can assist in the process of expedited underwriting and screening given their familiarity with telephonic interviews, prescription drug database tools, and other techniques.

A variety of cost structures were reported by survey participants for the ABR benefit included in life/LTCI linked-benefit plans. For one plan, there is no explicit cost, but there is a lien against the death benefit to provide the benefit. For three additional plans it was reported that there is a level charge based on per \$1,000 of NAR. Two of the final three plans assess a level charge based on per \$1,000 of face amount. The final plan is a single premium design, and there is a single premium charge for the ABR benefit.

For the EBR, the cost structure was reported for five of the seven plans. For three of the five plans, the cost structure is the same as that reported for the ABR. For two of these three plans the EBR and ABR charge is level, and for the third there is a single premium charge for both the EBR and ABR. The final two plans use a different cost structure for the EBR than the ABR. Four of the five plans use a level charge based on per \$1,000 of face amount or per \$X of LTC benefits for the extension of benefits rider. The fifth plan is a single premium design, and there is a single premium charge for the EBR benefit.

The majority of life/LTCI linked-benefit plans offer a marital discount. Five of the plans offer a marital discount and two of the plans do not. Five of the seven life/LTCI linked-benefit plans do not vary the marital discount depending on whether the benefit is purchased by one spouse versus both.

Six of the seven life/LTCI linked-benefit plans link the LTC underwriting classes to the life underwriting classes. The remaining plan does not link the LTC underwriting classes to the life underwriting classes.

All seven of the life/LTCI linked-benefit plans use a UL base plan chassis, and six of the seven plans commingle the rider premiums with the life premiums and reflect them in the base plan cash value mechanism. The rider premiums are not commingled with the life premiums or reflected in the base plan cash value mechanism for the final plan.

For all life/LTCI linked-benefit plans reported, the incidence of claims from 2010 through 2013 relative to that assumed in pricing was close to or better than expected.

In-house claims administration is used for five survey life/LTCI linked-benefit plans. For one of the five plans, a third party administrator is also used. Claims administration is also handled by a third party administrator for one of the final two plans. No response was received for the final plan.

Three of the seven life/LTCI linked-benefit plans are reinsured, and two plans are not reinsured. The reason why reinsurance isn't used was reported for the two plans that are not reinsured. For the first plan, it was reported that no reinsurance support was available at the time of pool implementation. This participant noted that it seems like reinsurers are now more willing to talk about reinsurance on life/LTCI linked-benefits, and the participant may include this benefit in its next request for proposal from

reinsurers. For the second plan, this participant is just starting to look at potential reinsurance support for its life/LTCI linked-benefit.

Two of the three reinsured life/LTCI linked-benefit plans are reinsured on a YRT basis. The third plan is reinsured on a coinsurance basis.

For all three reinsured life/LTCI linked-benefit plans, the reinsurer is paying its share of benefits at the time of rider claim.

Only one comment was received from survey participants regarding the implications of reinsuring the base life plan, but not the life/LTCI linked-benefit. For one plan, the ceded net amount at risk is “frozen” in the reinsurance administration system at the time the LTC rider claim begins. From that point on, YRT reinsurance premiums continue to be paid based on that ceded NAR amount, and the direct company collects that ceded NAR amount as the benefit payment at the time of the insured’s death (regardless of when / how much of the life benefit was previously accelerated).

The impact of including the LTC linked-benefit on factors such as policyholder optionality/anti-selection, mortality, policy persistency, and premium persistency was reported for six of the seven life/LTCI linked-benefit plans. For a two plans, it was reported that all assumptions were developed specifically for a combination product. The tables below include a summary of the impacts on policyholder optionality/anti-selection, mortality, policy persistency, and premium persistency reported for the remaining four Life/LTCI linked-benefit plans.

Appendix II Figure 97: Impact of Including the Life/LTCI Linked-Benefit

Impact of Including the Life/LTCI Linked-Benefit on Policyholder Optionality/Anti-Selection	Number of Plans
Increased policyholder behavior in early years based on ROP benefit.	2
Higher.	1
No change to base premium pattern, although most sales are for level premium track. No anti-selection at issue due to presence of a more lucrative net benefit on the LTC policy.	1

Impact of Including the Life/LTCI Linked-Benefit on Mortality	Number of Plans
No pricing difference, because data is sparse. Extra LTC underwriting probably provides improved mortality in practice.	1
Total population mortality is higher than other life insurance mortality due to simplified life underwriting.	1

Impact of Including the Life/LTCI Linked-Benefit on Policy Persistency	Number of Plans
No pricing difference. Improved benefit profile provides greater persistency for the mixed group.	1
Persistency increased over comparable life insurance product.	2
Lower	1

Impact of Including the Life/LTCI Linked-Benefit on Premium Persistency	Number of Plans
No difference to healthy pricing. Proportionally lower premiums adjusted for claims.	1
Higher due to single premium nature of product.	1
No impact (single premium product)	1

Four of the seven life/LTCI linked-benefit plans factor in the preservation of overall mortality, such that disabled life deaths, plus active life deaths equals the original deaths for life only.

Of the two respondents, LTC benefit utilization on the life/LTCI linked-benefit plan is assumed to be lower than that assumed on standalone LTC plans for one plan and it is not for the other plan.

For five of the seven plans, a separate additional active life reserve is calculated using standard LTC reserving methods. Two of those noted that this reflects the present value of LTC accelerated benefits offset by the death benefit reduction.

The majority of life/LTCI linked-benefits plans (five of the seven) hold separate additional active life reserves for the EBR and inflation protection benefit that are calculated using standard LTC reserving methods.

When the insured is receiving LTC ABR benefits from the life/LTCI linked-benefit, additional ABR disabled life reserves are held for five of the seven survey plans. For three of the five plans that hold an additional disabled life reserve, the separate additional reserve is calculated based on standard LTC claim reserving methods. For the final two of the five plans, the separate additional reserve is calculated based on standard LTC claim reserving methods, reflecting the present value of LTC accelerated benefits offset by the death benefit reduction.

When the insured is receiving LTC ABR benefits from the life/LTCI linked-benefit, additional disabled life reserves are held for the EBR and inflation protection benefit for the same five survey plans that do so for the ABR. A separate additional reserve is calculated based on standard LTC claim reserving methods.

When the insured is receiving LTC EBR and inflation protection benefits from the life/LTCI linked-benefit, additional disabled life reserves are held for six of the seven survey plans.

Comments about additional target surplus were reported for two life/LTCI linked-benefit plans. For the first plan, additional target surplus is based on 400% RBC factors used for stand-alone LTC. For the second plan, additional target surplus is held equal to a percentage of the LTC single premium plus a percentage of the LTC reserves and a percentage of the LTC claims.

For five of the seven plans, it was reported that a life and health license is required for the agent to sell this benefit. For the remaining two plans, it was specifically noted that agents are required to have a life and LTC license to sell the life/LTCI ABR.

Responses regarding the applicability of long term care insurance training requirements to the life/LTCI linked-benefit were received from all seven survey participants. For six of the seven plans, these requirements are applicable, and for the remaining plan, they are assumed to not be applicable.

Significant filing variations were reported for one of the seven life/LTCI ABR plans. For that plan, a variation was required in six different states. Details are in Appendix II.

Respondents indicated the states where life/LTCI linked-benefit plans are not approved. The most common states were California and New York (4 plans each) and Connecticut and Florida (3 plans each).

XIII. Executive Summary of Direct Writer Survey Pertaining to Annuity/LTCI Linked-Benefit Plan

Annuity/LTCI Linked-benefit plans include acceleration of the account value (without surrender charge) if the insured has a chronic illness condition (as defined under IRC Section 7702B), and the extension of long term care benefits over and above the accelerated account value (independent benefit).

Five of the 34 survey participants responded to questions relative to annuity/LTCI linked-benefit plans. One of the five provided responses for more than one annuity/LTCI linked-benefit plan. A total of six plans were reported for annuity/LTCI linked-benefit plans.

Total first year premium was reported by five survey participants relative to annuity/LTCI linked-benefit plans. The five participants reported sales for six plans. Four of the six plans are attached to single premium products, one is attached to a flexible premium product, and one company did not respond to this question. The table

below shows total sales by calendar year reported by survey participants, as well as the average and median sales per plan.

Calendar Year	Number of Plans	Appendix II Figure 102: First Year Premium – Annuity/LTCI Linked-Benefit Plans (\$ Millions First Year Premium)		
		Total	Average	Median
2011	5	\$25.0	\$5.0	\$3.4
2012	5	\$43.9	\$8.8	\$5.4
2013	6	\$319.7	\$53.3	\$14.3

Little information was received from the five survey participants relative to annuity/LTCI linked-benefit sales broken down by benefit elected, issue age range, and benefit design. Sales by issue age range were reported for three plans, and all sales were at ages 50 and over. Due to the low number of responses, no further details are reported to help preserve anonymity.

Total annuity/LTCI sales by distribution channel were reported for calendar year 2013 by four survey participants for five plans. Sales of annuity/LTCI linked-benefits were reported in four different channels by survey participants. In order to preserve anonymity, no sales information by channel is reported due to the low number of respondents at this level. However, the number of plans reporting sales in each of the channels is shown in the table below.

Appendix II Figure 103: Number of Plans with Sales by Channel – Annuity/LTCI Linked-Benefit Plans

Distribution Channel	Number of Plans
Agency Building	3
PPGA	2
Broker	1
Banks & Financial Institutions	2

Annuity/LTCI linked-benefits sold by survey participants are offered on a variety of annuity product chassis.

Of the five annuity/LTCI linked-benefit plans responding to Part II of the survey, three offer single life LTC options only. The final two plans offer both single life and joint life LTC options.

The benefit payment approach used for three annuity/LTCI linked-benefit plans is the expense reimbursement approach. Under this approach, reimbursement is based on actual expenses incurred for covered services, up to a daily or monthly cap. The final two plans used the indemnity approach. Under this approach, LTC expenses are reimbursed based on a specified amount per day or month, provided billable covered services are received.

Two of the four plans have a maximum lifetime benefit expressed as a percent of account value. The maximum lifetime LTC benefit for the first plan is 300% of account value. For the second plan, the maximum lifetime benefit is 200% or 300%, depending on the option chosen. For the remaining two plans, the maximum lifetime LTC benefit is expressed in terms of the initial deposit. The first of these two plans has a maximum lifetime limit of three times the initial deposit. The second has a maximum lifetime limit of two times or three times the initial deposit.

The waiting period that the annuity/LTCI linked-benefit rider must be in force before coverage begins is one year for one of the five plans. For two additional annuity/LTCI linked-benefit plans, the waiting period is zero to one year, depending on the state of issue. There is no waiting period for the final two plans.

When the annuity reaches its maturity date, the impact on the ABR/EBR varies by annuity LTCI linked-benefit plan. Two of the five plans terminate the ABR/EBR benefit at the annuity maturity date. For two additional plans, the policyholder has the option to extend the maturity date out by 12 months on a year by year basis. For the final annuity/LTCI linked-benefit plan, the LTC benefits become fully paid up based on the account value at maturity.

The table below shows all underwriting tools used for annuity/LTCI linked-benefit plans, along with the corresponding number of plans using the tool. One participant noted that one issue that is being discussed currently is if applicants with other findings that are not on the application should be rejected in the final underwriting decision. As a practice, the company has just been using these underwriting tools to verify responses on the application.

Appendix II Figure 108: Underwriting Tools Used with Annuity/LTCI Linked-Benefits

Underwriting Tool	Number of Plans Using
Application that is Supplemental to an Existing Annuity Application	4
Prescription Drug Screen	4
Phone Interview	3
Cognitive Screen	3
Face-to-Face Exam	2
Application Incorporated into the Annuity Application	1
Medical records or Attending Physicians' Statement	1

Of the five annuity/LTCI linked-benefit plans, three use in-house underwriters to underwrite the benefit, and two use third party underwriters.

Various charge structures are used by the five annuity/LTCI linked-benefit plans. A level basis points charge against the account value is used for two of the five plans.

The cost of the ABR/EBR for the third plan is based on cost of insurance rates applied to the excess of the lifetime LTC maximum over the account value. The final two plans assess a basis points charge against the remaining guaranteed amount.

One annuity/LTCI linked-benefit plan assesses a level basis points charge against the account value for the inflation protection benefit. For this plan, it was also reported that annual pour-in amounts on the contract anniversary are used. For one of the remaining four plans there is a basis points charge against the initial guaranteed amount less withdrawals other than for the LTC benefits. The third plan assesses a single charge assessed at issue for the inflation protection benefit.

Guarantees were reported for four of the five plans. One of the four plans has fully guaranteed charges/premium for the ABR/EBR. A second has a minimum guaranteed annuity interest rate, and the LTC rider is guaranteed renewable for life. One of the final two plans has a current charge accompanied by a maximum guaranteed charge for the ABR. For the EBR there is no guarantee on the current charge, and the charge can change after filing approvals. The final plan also has a current charge accompanied by a maximum guaranteed charge for the ABR. However, for the EBR, the current charge is guaranteed during the surrender charge period. There is no guarantee on the current charge after the surrender charge period, and the charge can change after filing approvals.

There is a separate charge for the nonforfeiture benefit included on all five annuity/LTCI linked-benefits reported in the survey.

Three of the five plans do not offer a marital discount and the final two offer a marital discount. Charges for the LTCI riders are on a unisex basis for all five survey plans. It will be interesting to see if companies move to sex-distinct rates as has been seen with stand-alone LTCI and some life/LTCI linked-benefit plans.

In-house claims administration is used for three of the five annuity/LTCI linked-benefit plans. The final two plans use a third party administrator.

Four of the five annuity/LTCI linked-benefits are not reinsured. For the final plan, it was reported that some of the business is reinsured and some is not. For the one plan that is reinsured, the form of reinsurance used is coinsurance, with reinsurance benefits paid at the time of LTCI claim.

The tables below include a summary of the various impacts on policyholder optionality/anti-selection, mortality, policy persistency, and premium persistency.

Appendix II Figure 110: Impact of Including the LTC Linked-Benefit

Impact of Including the LTC Linked-Benefit on Policyholder Optionality/Anti-Selection	Number of Plans
No Impact	1
Improved 20%	1

Impact of Including the LTC Linked-Benefit on Policyholder Optionality/Anti-Selection	Number of Plans
No Response	3

Impact of Including the LTC Linked-Benefit on Mortality	Number of Plans
No Impact	1
Targeting the Annuity Population; Does not Impact the Mortality of the Overall Population	2
No Response	2

Impact of Including the LTC Linked-Benefit on Policy Persistency	Number of Plans
Higher Policy Persistency	2
Significantly Higher Policy Persistency	2
Improved 20%	1

Impact of Including the LTC Linked-Benefit on Premium Persistency	Number of Plans
Improved 30%	1
No Response	1
Not Applicable - Single Premium Product	3

It was reported for four plans that the impact of including the annuity/LTCI linked-benefit resulted in enhanced profits. For the fifth plan, it was reported since the linked product and annuity have different profit targets, this question is not applicable.

LTC benefit utilization on the annuity/LTCI linked-benefit plan is assumed to be lower than that assumed on standalone LTC plans for three of the five survey plans.

As is true for linked-benefit life products, various opinions are held by survey participants regarding which agent licenses are required to sell the annuity/LTCI linked-benefit.

For the one annuity/LTCI linked-benefit plan that was filed with the IIPRC for five states, 43 state filings outside of the IIPRC were done.

Significant filing variations were reported for four of the five annuity/LTCI linked-benefit plans.

The types of filing variations by state, as well as the year when the annuity/LTCI linked-benefit plan are in Appendix II.

XIV. SOA Research Report – Long Term Care Insurance Accelerated Benefit Riders – Reinsurer Interviews

Only three reinsurers interviewed had reinsured Long Term Care Insurance Accelerated Benefit riders, and one had only one treaty. Most had not been asked to reinsure these riders, and several indicated that they would consider these if asked, but a couple expressed some concerns about the risks. One noted a management bias against anything with a long term care label, but a willingness to work with chronic illness riders. Another noted the disability model style benefits (which pay purely based on trigger requirements being met, regardless of whether formal care is provided) are in fact riskier than most stand-alone LTCI risks (which are predominately expense reimbursement model structures), due to the fraud that can occur when no formal care is provided. Note that chronic illness riders are required to use the disability model structure due to Model Regulation 620 and the IIPRC standards for accelerated benefits.

Many of these reinsurers stressed the importance of cognitive testing in underwriting these risks, especially at advanced ages. One expressed a preference for the “more robust” EMST test. Several referenced telephonic interviews, some in conjunction with cognitive testing, and a couple mentioned the value of prescription drug database screening.

One company noted that some of the risks are contained on these riders as they typically prescribe caps on the amount of benefits that can be payable over their lifetime, or in some cases, on a daily or monthly basis, particularly if they constrain benefits to the HIPAA limits.

XV. SOA Research Report – Life/LTCI Linked-Benefit Plans – Reinsurer Interviews

Only two reinsurers indicated that they have conducted any reinsurance of life/LTC linked-benefit products. They pay the direct writer at the time of LTC claim.

One reinsurer indicated that they were not comfortable with these risks. One indicated that they had a large inforce block of stand-alone LTC reinsurance that created some biases. One reinsurer commented that extension of benefit riders might be riskier than stand-alone LTC because claimant behavior on these new plans is not that well understood. There was some concern expressed about longevity of claims. On the other hand, another indicated that these linked-benefit plans represent a much lower risk than stand-alone LTC. It should be noted that there was a research report sponsored by the SOA and the ILTCI Conference Association in 2013 on the “Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long-Term Care Insurance”⁴ that highlighted the significant reduction in risks on combination products when compared to stand-alone LTC.

⁴ Linda Chow, Carl Friedrich, and Dawn Helwig, Quantification of the Natural Hedge Characteristics of Combination Life or Annuity Products Linked to Long-Term Care Insurance, 2013 Society of Actuaries and ILTCI Conference Association <http://www.soa.org/Files/Research/Projects/research-2012-03-quant-nat-hedge-report.pdf>

The comments relative to underwriting of LTCI riders extend to Life/LTCI Linked-benefits.

XVI. SOA Research Report – Annuity/LTCI Linked-Benefit Plans – Reinsurer Interviews

Two reinsurers indicated that they have participated in reinsurance of Annuity/LTCI Linked-benefits, with one inforce treaty coinsurance and the other reinsurer using YRT. One of these carriers expressed a preference for caps on maximum amounts payable under these riders (presumably in reference to periodic benefits). One reinsurer expressed their concern that underwriting should be conducted on these plans but that annuity producers were averse to that.

One reinsurer indicated that they were seeing a number of new annuity/LTCI products under development. They feel that the low interest rate environment is suppressing sales now, but expect this to explode once interest rates rise. This reinsurer views the risks of these products as between 50% and 75% of stand-alone LTCI risks. They also price the product (and life combos) with lower utilization but higher severity than they would use for stand-alone LTCI.

Annuity Enhanced Payout Benefits Triggered by a Health Condition

I. Defining Annuity Enhanced Payout Benefits Triggered by a Health Condition

Based on the authors' experience, some US variable and fixed indexed annuity insurers offer the option of an "LTC kicker" or "nursing home enhancement" (sometimes referred to on variable annuities as a VA doubler) within the guaranteed lifetime withdrawal benefit rider (GLWB) of the variable or fixed indexed annuity. These LTC kickers are not actually considered long-term care insurance, and do not qualify for special tax treatment under the Pension Protection Act. Rather, they provide a way for the policyholder to increase the withdrawal amount available under the GLWB rider to help pay for long term care costs. The amount of the increase depends upon the rider itself. For an extra fee, the provision may increase the annual GLWB amount by 50%, or double or even triple the annual GLWB amount, should the annuitant meet the qualification requirements for a nursing home enhancement. The increase may be effective for life, or for a limited period, such as five years. The LTC kicker benefits in the market provide some insurance leverage, but do not deliver monthly benefit levels that cover a meaningful portion of LTC costs.

As an example, a 65 year-old who had purchased an additional LTC kicker benefit as part of his GLWB may be receiving an annual GLWB withdrawal of 5%, but upon meeting the qualifications for the enhanced payout benefit, the 65-year old would then begin to receive 7.50% per year if the rider called for a 50% increase in the payout, or 10% if the rider called for a doubling of the payout. If the annuitant at some point no longer meets the qualification requirements, his annual withdrawal amount would drop back down the original payout of 5%.

Some companies offer the LTC kicker only on a single life basis, while others offer it on both single and joint life payouts. For the joint life option, the withdrawal percentages are normally based on the age of the younger spouse. As an example of the joint option, it is possible that one spouse (let's say the husband) enters a qualified nursing facility and qualifies for the increased withdrawals for a period of years, or possibly until his death. After his death, his wife receives the base annual GLWB withdrawal amount until such time she enters a nursing home, and can once again qualify for the increased withdrawal.

The IIPRC has not yet developed a Uniform Standard for this type of payout benefit. Therefore, companies wishing to offer it cannot currently file through the IIPRC. However, in the future the IIPRC does plan to develop Uniform Standards on this topic.

II. Cost of Benefit

Insurers normally charge an additional fee if the LTC kicker is purchased; this fee is in addition to the base fee charged for the GLWB rider itself. Some companies choose to offer the LTC kicker benefit on a single or joint life basis. If available on a joint basis, the fee may be higher than for single life. For example, the LTC kicker fee for single life may be 0.30%, while the fee for joint life is 0.50%. As an alternative to increasing the joint life fee, insurers may instead offer a lower enhanced payout on the joint life option (e.g., annual withdrawal amount increases by 25% instead of 50%).

III. Policyholder Taxation

No special tax rules apply on annuity enhanced payout benefits.

IV. Impact on Policy Pricing – Anti-Selection, Mortality, Policy Persistency and Premium Persistency Issues

If the same pool of applicants apply for this rider as pool of applicants who apply for the underlying annuity only, in terms of expected mortality, then the extra benefits provided to those insureds who meet the benefit trigger will increase the overall payout from the entire annuitant population. Some companies have rationalized their product offering under the theory that they can afford to provide enhanced benefits to the insureds who meet the benefit trigger since those individuals have lower life expectancies than the averages assumed in their pricing. This ignores the fact that those who never qualify for an enhanced benefit are healthier than that implied by the average mortality rate assumed for the overall pool. This suggests that the underlying annuity payout rates, before the enhancement, should be lower than would be used for a policy that does not offer the enhancement benefit.

To the extent that these products attract some risks who would not normally apply for an annuity, that can influence the mortality assumptions from those described above.

In addition, the presence of the enhancement benefit could have an impact on policy persistency. This would typically be a positive factor that might mitigate a portion of the concern about mortality described above.

V. Impact on Reinsurance Pricing and Administration

Reinsurers should be expected to factor in the same points made in the section above.

VI. Underwriting Considerations

No formal underwriting occurs when companies offer enhanced payouts due to a health issue. However, several companies have certain requirements both in order to purchase the enhanced payout benefit, and in order to qualify for enhanced payouts to begin.

Requirements that insurers may impose to be eligible to elect the LTC kicker include:

- The annuitant(s) cannot already be confined in nursing home
- May not already be unable to perform 2 of 6 Activities of Daily Living
- Age limits at time of rider purchase

Insurers may impose some or all of the following requirements before the enhanced payout takes effect:

- Waiting period – Most include some type of waiting period before the enhancement benefit may be used, such as a one-, two- or five-year period from the date the rider was purchased.
- Age requirement, e.g. over age 50
- Elimination period – The company may require that the insured be confined in a qualifying facility a certain time period, for example 180 of the last 365 days, or a 90-day period. (Usually, the waiting period and elimination period may occur simultaneously.)
- Several require confinement in a qualified nursing facility. Companies create their own definition of what types of facilities qualify; there are no state or federal requirements. Companies may choose to categorize facilities such as assisted living, rehabilitation hospitals, drug or alcohol rehab centers, and adult foster care as not qualifying under the rider.
- Instead of requiring confinement in a qualified nursing facility, some riders use the qualification of being unable to perform two of six activities of daily living (an expectation of permanence may be required) as the basis for whether the enhanced payout will occur.

Should the annuitant be discharged from the nursing facility or no longer meets the 2 of 6 ADLs requirement, then the annual withdrawal benefit is normally adjusted back to its original amount.

VII. Executive Summary of Direct Writer Survey Pertaining to Annuity Enhanced Payout Benefits

No companies responded to the section of the survey pertaining to Enhanced Annuity Payouts.

VIII. SOA Research Report – Enhanced Annuity Payout Benefits – Reinsurer Interviews

We did not identify any use of reinsurance on Enhanced Annuity Payouts. A couple of reinsurers seemed open to the possibility, but had not been approached by any carriers.

One company noted that for the enhanced payout benefit, if direct writers are not recognizing in pricing that those who don't take this benefit tend to have lower mortality than average risks, that could be a concern if the reinsurer is also asked to reinsure the non-enhanced payouts. This reinsurer would recognize this dynamic in its pricing.

Appendix I: Glossary

AB: Accelerated benefit

ABR: Accelerated benefit rider

ADB: Accelerated death benefits

ADLs: Activities of daily living

Annuity enhanced payout benefits triggered by a health condition: Also called “nursing home enhancement” or “LTC kicker”. An increased withdrawal amount available under the GLWB rider on an annuity to help pay for long term care costs.

Annuity/LTCI linked-benefit plan: A plan that combines an annuity base policy with both an LTCI accelerated benefit rider and an LTCI EBR.

COI: cost of insurance, a charge assessed periodically to cover the cost of providing insurance

Coinsurance approach: Under linked-benefit annuity products, a design featuring the payment of LTCI benefits that are provided in part by the use or acceleration of base plan values, and concurrently in part from general insurance company funds. Total lifetime LTCI benefit payment limits are normally defined in terms of account value at the time an LTCI claim first occurs.

Compound inflation benefit (5 percent): A policy feature that annually increases the periodic daily or monthly LTCI benefit limit by 5 percent over the prior year level, and at the same time increases the lifetime maximum limit by 5 percent over the prior year level. (In some policies, the previously *unused* lifetime maximum limit is inflated.)

EBR: Extension of benefit rider

GLWB: Guaranteed Lifetime Withdrawal Benefit

HIPAA: Health Insurance Portability and Accountability Act

IIPRC: Interstate Insurance Product Regulation Commission

IRC: Internal Revenue Code

Life/LTCI linked-benefit plan: A plan that combines an annuity base policy with both an LTCI accelerated benefit rider and an LTCI EBR.

Long term care insurance riders (LTCI riders): Long term care insurance accelerated benefit rider. Accelerates only the death benefit, with no extra pure insurance component. Also called “LTC Rider” or “LTC Services Rider”.

LTCI pool amount: The maximum lifetime LTCI payment limit

NAIC: National Association of Insurance Commissioners

NAR: Net amount at risk

Pool design: Under annuity/LTCI linked-benefit products, a design featuring the payment of LTCI benefits that are first provided by the use or acceleration of base plan values up to a dollar limit of benefits equal to the account value, and subsequently from general insurance company funds up to a maximum lifetime LTCI payment limit. That limit is predefined at issue, and at times is expressed as a multiple of the policy’s single premium.

PPA: Pension Protection Act of 2006

Tail design: Under annuity/LTCI linked-benefit products, a design featuring the payment of LTCI benefits that are first provided by the use or acceleration of base plan values up to some limit specified in terms of years or dollars of benefits, and subsequently from general insurance company funds. Total lifetime LTCI benefit payment limits are normally defined in terms of account value at the time an LTCI claim first occurs.

Appendix II: Life and Annuity Living Benefits Survey (separate document)

Appendix II includes the Report on Life and Annuity Living Benefits Survey and is in a separate document.

Appendix III: Reinsurers Participating in Interviews

Canada Life Re

Gen Re

Hannover Re

Munich Re

Optimum Re

RGA

SCOR

Swiss Re